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No. 92-1637

Supreme Court
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IN THE SUPREME COURT OF THE UNITED STATES
October Term, 1992

IRENE M. IBARRA, in her official capacity as the Executive Director of the COLORADO DEPARTMENT OF SOCIAL SERVICES; HENRY SOLANO, in his official capacity as the Executive Director of the COLORADO DEPARTMENT OF INSTITUTIONS; ROBERT BAUSERMAN, ROBBIE L. BEAN, SUSANNE D. DOSH, DENNIS FISHER, MARY KYER, PEGGY STOKSTAD, JOHN P. STONE, and RICHARD F. WALKER, in their official capacities as members of the COLORADO BOARD OF SOCIAL SERVICES,

Petitioners,

vs.

DUC VAN LE, on behalf of himself and the class of persons similarly situated,

Respondents.

RESPONDENTS' APPENDICES
(Exhibits A - D)

EXHIBIT A

DISTRICT COURT, CITY AND COUNTY OF DENVER, COLORADO

Case No. 88 CV 22641

STIPULATED FACTS

DUC VAN LE, on behalf of himself and the class of persons similarly situated,

Plaintiffs,

v.

IRENE M. IBARRA, in her official capacity as Director of the COLORADO DEPARTMENT OF SOCIAL SERVICES; HENRY SOLANO, in his official capacity as Director of the COLORADO DEPARTMENT OF INSTITUTIONS; ROBERT BAUSERMAN; ROBBIE L. BEAN, SUZANNE D. DOSH; DENNIS FISHER; MARY KYER; PEGGY STOKSTAD; JOHN P. STONE; RICHARD F. WALKER, in their official capacity as members of the COLORADO BOARD OF SOCIAL SERVICES,

Defendants.

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1. Plaintiff Duc Van Le is a 35 year old Vietnamese refugee who came to the United States in 1975.

2. Plaintiff's entire family remained in South Vietnam when he was sent to this country and, therefore, plaintiff suffered severe emotional trauma as a result of this precipitous separation from his family.

3. During the first three years plaintiff was in the United States, he worked a number of jobs, including electronic assembly, general labor with Coors, restaurant work, etc. He tried to build a new life, but he began to suffer severe depression with psychotic features. He attempted suicide by taking an overdose of aspirin, but recovered.

4. In 1982, Duc Van Le was treated at Park East Mental Health Center while living at the Adams Manor Nursing Home.

5. Duc Van Le was also temporarily hospitalized for a period of time at Fort Logan Mental Health Center.

6. Duc Van Le has displayed a history of schizophrenia, paranoiac in nature since 1982. He has a significant learning disability associated with a speech impediment in his native language of Vietnamese and suffers from tardive dyskinesia, a motor defect secondary to his medication for the schizophrenic behavior. Because of symptoms of auditory and visual hallucinations, severe depression and anxiety, which have been a danger to himself and others, he has consistently been in and out of hospitals and nursing homes for his care. When Duc Van Le has been institutionalized, Medicaid reimbursement covers the cost.

7. In May 1984, Duc Van Le was staying at the Sunshine Health Care Center and in treatment with Adams Community Mental Health Center.

8. Duc Van Le began treatment with the Asian-Pacific Center in December 1984. He received partial care twice a week and individual treatment on an as-needed basis. He also received vocational rehabilitation services. At times, plaintiff's behavior was relatively stable and he was able to function appropriately. At other times, he was highly disruptive and violent. Through a series of consultations with medical staff at the Sunshine Center and the Asian Pacific Center psychiatrists, plaintiff's medication was stabilized.

9. In February 1988, noticing plaintiff's progress and sensing that the environment of the Sunshine Center was not conducive to further improvement for plaintiff, the Asian Pacific Center contacted the Atlantis Community, Inc. and made plans for plaintiff to be moved to an independent living situation.

10. Plaintiff was moved to an independent living situation with continued supervision by the Atlantis Community and has remained relatively stable since that time. Movement out of the nursing home and into an independent living situation has allowed plaintiff to grow and progress in ways previously unattainable while in a sheltered living environment such as a Title XIX skilled or intermediate care nursing home.

11. On the basis that Duc Van Le requires 24-hour, five days a week skilled nursing supervised care, an application was taken by the Denver Department of Social Services in August, 1988 for HCBS entitlement.

12. On August 18, 1988, the Colorado Foundation for Medical Care (CFMC) conducted an admission review based upon the psychiatric diagnosis of schizophrenia.

13. The call-in assessment by Carla Montez, medical coordinator for Atlantis Community, Inc., was scored by the CFMC as follows: five points were assessed in the area of "Contact with Reality" on the basis of visual and audio hallucinations which were

not necessarily harmful to him but required constant intervention by the home health care provider or other person. Five points were assessed in the area of "Behavior" based upon a history of noncompliance with medication and potential harm to self, verbal abuse, and sometimes disruptive behavior. Two points were assessed in the area of "Communication" based upon learning skills of English. Duc Van Le does not speak English and he has a speech impediment in his native tongue. One point was assessed in the area of "Bathing" and one point was assessed in "Dressing" based upon the requirement of verbal assistance needed. Two points were assessed in the area of "Supervision" based upon the mental health care counseling required weekly and monitoring of medications twice daily. Five points were assessed in the area of "Living Skills" with deficits in cooking, shopping, managing money, cleaning house, and laundry. The total point score of 21 points was determined by the ALJ and the CFMC to be sufficient to meet the threshold requirement for Medicaid reimbursement for HCBS services.

14. At the time of this assessment, Duc Van Le qualified financially for HCBS, but was not otherwise eligible for Medicaid services. Because he receives Social Security Disability (DDS) of $374 monthly, his income is $24 higher than the need standard for the ordinary Medicaid program. However, Duc Van Le does qualify financially for the HCBS program under the 300% rule since his income is less than 300% of the Social Security Income Need Standard.

15. Despite the fact that Duc Van Le met both the financial screening and medical guidelines for the HCBS program, the Colorado Foundation for Medical Care, under state regulations 10 C.C.R. 2505-10, Sections 8.401.19, 8.402.32 and 8.485.43, was required to make a referral of Duc Van Le's case to the State Department of Social Services for target group designation based upon psychiatric diagnosis.

16. The Colorado Department of Social Services subsequently determined that Duc Van Le was in the target group of mental health as a result of his psychiatric diagnosis and, therefore, the Department denied Medicaid reimbursement for home and community based services (HCBS) for Duc Van Le.

17. If Duc Van Le's need for services had been based on physical disability instead of mental disability, he would have been granted HCBS services.

18. A timely appeal of the Department of Social Services' decision was taken on behalf of Duc Van Le by the Atlantis Community and the Asian Pacific Center. The Department of Institutions was not a party to this administrative proceeding.

19. An administrative hearing was held on October 18, 1988 and Administrative Law Judge Moeller ruled that, although Duc Van

Le qualified medically for home and community based services under the medical screen performed by the CFMC, there is no availability for Medicaid reimbursement for home and community based services for individuals designated as mentally ill.

20. Plaintiff filed a timely action for judicial review of this administrative decision, pursuant to C.R.S. 24-4-106.

21. Defendants Robert Bauserman, Robbie Bean, Suzanne Dosh, Mary Kyer, Peggy Stokstad, John Stone, Richard Walker, Dennis Fisher and David Trujillo are members of the Colorado Board of Social Services (CBSS) and are, in their official capacity, responsible for the promulgation and repeal of rules and regulations governing the Medicaid program's scope and content, including the rights of recipients and the allocation of Medicaid benefits among eligible persons. C.R.S. 26-1-108(1)(b).

22. Defendant Irene M. Ibarra is the director of the Colorado Department of Social Services (CDSS), which is a principal department of the state of Colorado and is, in her official capacity, responsible for the administration and supervision of all public assistance programs in the State of Colorado, including the Medicaid program. C.R.S. 26-1-111.

23. Defendant Henry Solano is the director of the Colorado Department of Institutions (DOI). In his official capacity and in conjunction with the Department of Social Services, he has been delegated certain responsibilities and authority to provide home and community based services for the mentally ill under C.R.S. 26-4.5-204.

24. Defendants are all officials or employees of the State of Colorado, and were acting officially under color of state law when performing the actions complained about in this lawsuit.

25. The plaintiff class, as previously certified by this Court, is composed of all low income residents of Colorado who, because of their mental illness, qualify for skilled or intermediate care under Title XIX of the Social Security Act, but who have been and are being deprived by the State of Colorado of home and community based services under Title XIX of the Social Security Act, which are necessary to meet their needs, solely on the basis of their mental illness, although such services are provided to physically disabled adults, and who claim that this deprivation violates their rights under the Social Security Act, the Rehabilitation Act of 1973, and the Fourteenth Amendment of the United States Constitution.

26. HCBS programs are statutorily authorized by Section 1915(c) of the Social Security Act. This provision of the Social Security Act authorizes HCBS for:

a. elderly, blind and physically disabled persons;

b. mentally ill persons; and

c. developmentally disabled persons.

42 C.F.R. 441.301(b)(6) This statute has been continuously in effect from the 1970s to the present.

27. The purposes of the HCBS programs are to prevent unnecessary institutionalization of the above three populations, to contain the costs of long-term nursing home care and to provide more appropriate community based services for these populations.

28. The HCBS waiver programs are jointly funded by the federal government and states, with the federal government paying between 50% and 75% of the cost under the Medicaid Title XIX program.

29. In order to secure this financial reimbursement for HCBS programs, states must submit Section 1915(c) waiver applications to the federal government and must demonstrate, among other requirements, that the cost of HCBS programs is less than the cost of Medicaid reimbursed nursing home care for eligible individuals. 42 U.S.C. Section 1396n(c)(2)(D); 42 C.F.R. 441.302; Section 26-4.5-104.5(3) C.R.S. 1989.

30. In 1980, the General Assembly enacted C.R.S. 26-4.5-101 through 26-4.5-211.

31. From 1982 to 1985, the State of Colorado sought and obtained 1915(c) waivers from the federal government and provided services under Title XIX of the Social Security Act not only to the elderly, blind, disabled and developmentally disabled, but also to the mentally ill.

32. In 1985, the State of Colorado applied for an extension of its HCBS mentally ill waiver program. The federal government requested that the state withdraw its initial application and resubmit it. The state did so. (See Exhibit 1).

33. In its resubmitted 1985 application, the State of Colorado gave assurances to the federal government that it could operate an HCBS program for mentally ill persons at a lesser cost than would be required to institutionalize such persons in skilled or intermediate care nursing homes.

34. Colorado's resubmitted HCBS 1985 mentally ill waiver request was denied by the federal government for reasons set forth in Exhibit 2.

35. After receiving the federal government's denial of its 1985 HCBS program for the mentally ill waiver request, Colorado chose not to submit a revised application.

36. As a result, the Board of Social Services enacted regulations which terminated the HCBS program for the mentally ill, although the Colorado statute governing such a program remained in effect.

37. From 1985 to the present, Colorado has not operated an HCBS 1915(c) waiver program for the mentally ill.

38. Since 1985, Colorado has continued to operate HCBS 1915(c) waiver programs for the elderly, blind and physically disabled and for developmentally disabled persons.

39. The Colorado HCBS program for the elderly, blind and physically disabled persons and for developmentally disabled persons is designed to allow such persons to live independently in the community and to avoid more costly skilled and intermediate care nursing home placements which they would otherwise require if not provided services under the HCBS program.

40. The HCBS program services for the elderly, blind and physically disabled, as defined by C.R.S. 26-4.5-104.5, include the following:

> Home health services; personal care services; respite care services; nonmedical transportation services; environmental home modification and electronic monitoring services; case management services; homemaker services; and adult day care services.

41. Homemaker services under the HCBS program for the elderly, blind and physically disabled include assistance with general household activities, including preparation of meals, routine household techniques that promote self care, independent living and nutrition, and incidental personal care.

42. Personal care services under the HCBS program for the elderly, blind and physically disabled include assistance with personal hygiene, dressing and eating, ambulatory needs including transportation necessary to provide access to services, household tasks incidental to the persons's health care needs or otherwise necessary to maintain the person at home. These and the other above described HCBS program components for the elderly, blind and physically disabled are set forth in full detail in C.R.S. 26-4.5-103.

43. These same services would be of great benefit to Duc Van Le and the class of mentally ill persons he represents. Indeed, the Executive Director for the Department of Social Services,

George Goldstein, referred to these same services in 1985 as being "essential to the care and treatment of the long term mentally ill population" and "to the containment of costs for skilled and intermediate nursing care for this population." (Exhibit 3).

44. The State of Colorado, under Section 1915(c) of the Social Security Act, could submit a waiver request for the mentally ill population under which it could provide the very same services that are currently being provided to the elderly, blind and physically disabled persons.

45. There is no alternative state program which provides for Duc Van Le and the class of mentally ill persons he represents the same HCBS program services which are currently being provided to elderly, blind and physically disabled persons.

46. Even though Duc Van Le and the members of the plaintiff class meet all of the financial and medical screens for HCBS services, they have been and will be denied these service solely on the basis that their primary diagnosis is mental illness.

47. State defendants have denied at least 28 individual class members HCBS services, whom they can identify by name, since March 1987.

48. Additional class members have been directly denied HCBS services solely on the basis that their primary diagnosis is mental illness, but state defendants do not have records of such denials.

49. The termination of the HCBS program for the mentally ill in 1985 has deterred other class members from applying for benefits.

50. Six hundred and thirty-five persons, whose primary diagnosis is mental illness, currently reside in Medicaid certified nursing homes in Colorado.

51. Defendants and their counsel drafted legislation and actively supported such legislation in the last term of the Colorado Legislature to expressly repeal language in C.R.S. 26-4.5-201 which authorized defendants to seek an HCBS waiver under Section 1915(c) of the Social Security Act for the plaintiff and class members while leaving such authority in effect for the elderly, blind, physically disabled and developmentally disabled. See Exhibit 4 hereto. Although this bill includes a legislative finding that the federal government would not approve Colorado's HCBS waiver request for the mentally ill, no such communication from the federal government was presented to the General Assembly to support this finding. Indeed, the last communication directly received by the state from the Secretary of Health and Human Services concerning these issues was the August 28, 1985 letter from Secretary Heckler, which is attached as Exhibit 5.

52. The current position of the U.S. Department of Health and Human Services regarding the availability of Section 1915(c) HCBS waiver programs for the mentally ill is reflected in the May 17, 1990 letter to Congresswoman Patricia Schroeder from Gail R. Wilensky, Administrator of the Health Care Financing Administration of the U.S. Department of Health and Human Services, which is attached hereto as Exhibit 6.

53. The replacement clinic option program for HCBS for mentally ill persons, funded in part with federal Medicaid funds, is not available to persons like Duc Van Le who fall into the 300 percent category of persons who would have been financially eligible for the HCBS program services. The State provides community mental health services for persons like Duc Van Le, with fees assessed based on the recipient's ability to pay.

54. The existing state programs for mentally ill persons do not provide:

a. home health care services;

b. personal care services;

c. respite care services;

d. non-medical or non-treatment transportation services;

e. environmental home modification and electronic monitoring services; and

f. homemaker services.

55. Plaintiffs and class members are protected handicapped persons within the meaning of 29 U.S.C. 793 which is popularly known as Section 504 of the Rehabilitation Act of 1973 and its implementing regulations.

56. As indicated above, the Home and Community Based Services programs operated by the State of Colorado receive federal financial assistance.

57. The certified record of the Administrative Proceedings on file with this Court and the Exhibits attached hereto are to be admitted into evidence in this proceeding.

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Exhibit 1

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GOVERNOR

State of Colorado

DEPARTMENT OF SOCIAL SERVICES

1575 SHERMAN STREET
DENVER, COLORADO 80203

GEORGE S. GOLDSTEIN Ph.D.
Executive Director

Margaret Heckler, Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D. C. 20201

Dear Secretary Heckler:

The State of Colorado hereby requests a Secretarial waiver under section 2176 of the Omnibus Budget Reconciliation Act of 1981 for authorization to provide personal care, non-medical transportation, homemaker services, respite care and case management services in a program of home and community-based services to mentally ill persons who, in the absence of the waiver, would require institutionalization in an intermediate or skilled nursing facility.

Specifically, the State is requesting a waiver under the provisions of section 1915 (c) of the Social Security Act and a waiver of section 1902 (a) (10) of the Social Security Act for the amount, duration and scope of services. The requested authorization is for the three-year period from October 1, 1985 to October 1, 1988.

This request was orginally submitted May 31, 1985, as a renewal request for the State's waiver for the mentally ill which was approved January 6, 1983, effective October 1, 1982. On June 7, however, the State was asked to withdraw the renewal request and resubmit as a new request because of a change in the services package, mandated primarily by the March 1985 change in 42 CFR 440.180. The State considers continuation of this program essential 1) to the care and treatment of the long term care mentally ill population currently being served through this program and 2) to the containment of costs for skilled and intermediate nursing care for this population.

The attached request document has been developed in compliance with 42 CFR 440.180 and Subpart G of Part 441, as published March 13, 1985, in the Federal Register. Section IX of the document provides a summary of the State's assurances and documentation for those assurances.

Thank you for your consideration of this request.

Sincerely,

George S. Goldstein, Ph.D.
Executive Director

cc: Frank Traylor, M.D., Executive Director
Colorado Department of Institutions

STATE OF COLORADO

REQUEST FOR WAIVERS UNDER

SECTION 1915 (c)

AND 1902 (a) 10

OF THE SOCIAL SECURITY ACT

TO PROVIDE HOME AND COMMUNITY-BASED SERVICES

TO THE MENTALLY ILL

July, 1985

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INTRODUCTION

In 1981, in recognition of the existing statutory barriers to the utilization of non-institutional settings for the delivery of services in a cost-effective manner to individuals who would otherwise require the level of care provided in a skilled nursing facility (SNF) or an intermediate care facility (ICF), the Congress amended the Social Security Act through the provision of section 2176 of Public Law 97-35, the Omnibus Budget Reconciliation Act, to permit states to offer, under a Secretarial waiver, a wide array of home and community-based services that an individual may need to avoid institutionalization.

Shortly after the passage of this Act, the State of Colorado submitted requests for waivers to serve three distinct population groups--the elderly, blind and disabled, the developmentally disabled and the mentally ill. All three requests were approved--the waiver for the elderly, blind and disabled, effective July 1, 1982; and the waivers for the developmentally disabled and the mentally ill, effective October 1, 1982.

The State has recently submitted renewal requests for its waivers for the elderly, blind and disabled and for the developmentally disabled and, with this submission, the State of Colorado is requesting continuation of its waiver approved January 6, 1983, effective October 1, 1982, to provide home and community-based services to the State's long term care population having a diagnosis of mental illness. The current, approved waiver for this population will expire October 1, 1985.

This request to continue the provision of home and community-based services to the mentally ill was originally submitted to the Health Care Financing Administration (HCFA) on May 31, 1985, as a renewal request. On June 7, 1985, however, it was recommended by HCFA staff that the State withdraw its renewal request because of a proposed change in the home and community-based waiver services package. The State was advised to submit a request for a new waiver for this population. Although the primary change in the waiver services package was mandated by the March 13, 1985, change in 42 CFR Section 440.180 which now prohibits the provision of a regular service under a State's Medicaid Plan as a home and community-based service, the State agreed to withdraw its renewal request and to re-submit as a new request.

For the three year period beginning October 1, 1985, and ending September 30, 1988, therefore, the State requests a waiver under Section 1915 (c) of the Social Security Act to provide a cost-effective program of home and community-based services to mentally ill individuals who would otherwise require institutionalization in an SNF or ICF and a waiver of the requirements of 1902 (a) (10) for the amount, duration and scope of services.

SECTION I. OVERVIEW

A. Colorado's Mental Health System

Article 27 of Colorado Revised Statutes places with the Colorado Department of Institutions the responsibility for administration of the State's programs and services for the mentally ill. State services are provided principally through two State-administered hospitals--Colorado State Hospital in Pueblo and Fort Logan Mental Health Center in Denver--and twenty-two private, non-profit community mental health centers and clinics (CMHC's) from whom the State purchases services. The Division of Mental Health of the Colorado Department of Institutions is the administering agency for state services for this population.

State hospital services are reserved for those individuals most in need of intensive inpatient treatment and care and are generally provided on a short-term basis with the goal of returning the client to a community-based setting as soon as treatment will allow. State hospital populations, in line with national trends, were substantially reduced during the 1960's and 70's when the State hospitals underwent a transition from serving primarily as locales for housing and restriction of mentally ill individuals to facilities providing intensive short-term treatment. The Colorado mental health system, from the early 1970's, has reflected an orientation to community-based services through the locally-managed community mental health centers and clinics. Services provided by the CMHC's range from the purchase of intensive short-term psychiatric inpatient services to less intensive outpatient and consultation/education services. To ensure the availability of community mental health services throughout the State, each CMHC is required to provide a minimum set of services in the unique geographical, or catchment, area which it serves.

Because of its commitment to the provision of services in the most clinically appropriate, least-restrictive setting, Colorado is continually seeking to strengthen its community-based service system for the mentally ill. In recent years, additional State funding to offset declining federal support under applicable national programs has been provided and, in 1979, Colorado moved to qualify clinic services provided by the community mental health centers and clinics to Medicaid-eligible recipients as medical assistance clinic services under the provisions of 42 CFR 440.90.

The seriously, critically, and chronically mentally ill, however, who no longer require the intensive inpatient psychiatric treatment provided by one of the State hospitals, but who do require a structured residential setting, have continued to be placed in skilled or intermediate nursing care facilities. These settings are utilized for both State hospital discharges and placements from the community. In 1981, the State strengthened the quality of mental health services available to clients in nursing home settings by extending the Medicaid clinic option services to this population.

Institutionalization in a nursing home setting, even with the provision of mental health treatment, however, has continued to be a costly mode of treatment, providing less than optimal treatment outcomes in unnecessarily restrictive settings. Prior to the passage of the Omnibus Budget Reconciliation Act of 1981, however, the inherent biases in Medicaid led the State to rely heavily on the SNF/ICF placements for the seriously, critically and chronically mentally ill.

B. Approved Waiver for the Mentally Ill

With the passage of the Omnibus Budget Reconciliation Act, however, the State of Colorado in 1982 requested a waiver under the provisions of section 1915 (c) of the Social Security Act and a waiver of the requirements of section 1902 (a) (10) relating to the amount, duration, and scope of services. The State's waiver request for the mentally ill population was approved January 6, 1983, retroactive to October 1, 1982.

Due to the retroactive effective date of the waiver and the need to secure State statutory and regulatory authority for the approved waiver program, the first client was not admitted to the waiver program for the mentally ill until November 6, 1983. Even then, client enrollment proceeded more slowly than had been anticipated.

Because of the severity of the medical and physical problems of many of the mentally ill target population in nursing homes and the length of time many have resided in these institutional settings, deinstitutionalization of individuals from nursing homes has been less than anticipated. Case managers for the Home and Community-Based Services--Mental Health (HCB-MH) program have found many long-term nursing home clients reluctant to leave the security and familiarity of the nursing home. For example, out of 93 nursing home clients for whom the Spanish Peaks Community Mental Health Center conducted evaluations from June 1984 to June 1985 to determine the appropriateness of alternative placement, 55 had moderate to severe physical problems and only two chose the alternative HCB-MH program. Also, out of 78 mentally ill clients referred to the Center for whom the Center had data relating to the admission date of the client to the nursing home, 33 had been in the nursing home for more than five years. According to the case manager for the Pikes Peak Center:

> These people did not want to move because the nursing home had become their "home."
>
> I believe that evaluation for alternative placement should be done before the client is placed into the nursing home. Once the client has moved into the nursing home, they do not want to move again, and their families are usually against moving them out of the nursing home. (Terri J. Gerner, Spanish Peaks MHC).

Start-up of the HCB-MH program was also slowed by the reluctance of some of the CMHC providers to participate in an administratively-administratively-complex program requiring State-level involvement in service delivery. Prior to the start-up of the waiver program, the State had purchased services from the community mental health centers and clinics through performance contracts and had established and enforced service standards, but had no direct input into the level of treatment which could be provided an individual client. The waiver program with its emphasis on cost-effectiveness imposed on Colorado's community mental health system both a greater involvement of the State in actual services provision and a paperwork and administrative structure more complex and heavier than this system has previously known. For example, in order to ensure that the cost-effectiveness requirements of the waiver would be met, the State has required, not just the approval of Plans of Care which exceed one hundred percent of the cost of nursing home care as specified by the approved waiver, but, instead, that all Plans of Care for HCB-MH clients be approved by the State.

Despite the delay in the start-up of the program, however, and the administrative problems necessarily entailed in a program in which the State, contrary to its usual policy, became heavily involved in the approval of services on a client-by-client basis, the HCB-MH program is currently operating smoothly and it is estimated that the unduplicated client count for the final year of the approved waiver will be 382. Based on the projected estimate of the September 30, 1985, unduplicated client count, the total long term care savings for this program is estimated at $157,000 for Federal Fiscal Year 1984-85, with similar annual amounts estimated for the subsequent three-year period for which the new waiver is being requested.

In summary, although the State has had less than two years experience with this program, the Home and Community-Based Services--Mental Health (HCB-MH) program is now considered to be an important component in the State mental health system's continuum of care for the seriously, critically or chronically mentally ill. Termination of home and community based services for the estimated 246 clients enrolled as of June 30, 1985, would have not only a serious and adverse impact on the care and treatment of this client population but, over the next three year period, would significantly increase the cost of long term care in Colorado.

C. Request for New Waiver

The waiver program for which approval is being requested for the period from October 1, 1985, through September 30, 1988, will not vary substantially from the current alternative care program for this population. The major change relates to the new prohibition contained in 42 CFR 440.180, as published March 13, 1985, in the Federal Register. This section was revised to prohibit a service which is a regular service of Medicaid from being offered as a home and community-based service. Medicaid clinic option services, a

regular service of Medicaid under the State Plan, has been a major component of the treatment plans for HCB-MH clients in independent living settings and, along with personal care and non-medical transportation, has been a component of the treatment for clients in the waiver program's two residentially-based treatment settings. Under the authorization being requested at this time, Medicaid clinic option services will continue to be provided to this population, but expenditures for this service will be included in D' of the cost-effectiveness equation, rather than in D, as is the case with the current waiver.

Specifically, the State is requesting a waiver under Section 1915 (c) of the Social Security Act to provide a cost-effective program of home and community-based services to mentally ill individuals who would otherwise require institutionalization in an SNF or ICF and a waiver of the requirements of 1902 (a) (10) for the amount, duration and scope of services.

The State of Colorado is requesting authorization to provide the following services to the State's seriously, critically and chronically mentally ill from the period from October 1, 1985, through September 30, 1988:

Case Management Services
Homemaker Services
Personal Care Services
Respite Care Services
Non-medical Transportation Services

The following section establishes the goal of the waiver and Section III defines and describes the target population. Section IV, describes, in detail, the home and community based services program to be provided under the requested authorization, including program administration; eligibility requirements and procedures for determination of eligibility and admission to the program; and, finally, plan of care requirements and the qualifications of the individuals who will be responsible for developing the individual plans of care. Section V describes the services to be provided; Section VI describes the State's requirements for service providers and Section VII discusses facility standards. Section VIII relates to the cost-effectiveness of the proposed program and Section IX provides a summary of the State's assurances and the documentation of the assurances as required by 42 CFR 441.302 and 441.303.

SECTION II: GOAL OF THE WAIVER

The goal of this waiver request is to provide more appropriate, cost-effective home and community-based services to approximately fifty-five per cent of the State's seriously, critically and chronically mentally ill who are being--or who, in the absence of the waiver, would be--served in skilled or intermediate nursing care facilities. It is the belief of the State that, despite the provision of Medicaid clinic option services to this population in their nursing home placements, the treatment outcomes for this portion of the long term care population could be improved by the provision of more appropriate care in less restrictive home or community-based settings.

For slightly less than thirty percent of the target population, short-term intensive mental health treatment in a more costly, community-based residential care facility will be required prior to placement, at a significant cost savings, in independent living settings with continued case management and the provision of regular Medicaid clinic option services. Although the cost-effectiveness of this waiver program is based on an aggregate calculation of the cost-effectiveness of the total program on an annual basis, it is the State's contention that, over a three-year time span, home and community-based services will prove to be cost-effective on an individual client basis for approximately 95% of the total waiver population. Clients not proving to be progressing satisfactorily over a three-year time span and for whom services are not cost-effective on an individual basis for this period will be denied home and community-based services.

SECTION III. TARGET POPULATION

A. Definition

The target population of this waiver request includes all those persons currently enrolled in the State's approved waiver, Home and Community Based Services--Mental Health, and all individuals:

1) who are currently in an SNF or ICF or who are determined to be at risk of placement in an ICF or SNF by application of the applicable level of care guidelines by the State's Professional Review Organization;

2) who have been determined to be Medicaid eligible or who have filed an application for Medicaid services with the appropriate county department of social services;

3) who are assessed by the community mental health centers or clinics as being seriously, critically, or chronically mentally ill;

4) who do not present significant medical barriers to community placement;

5) who could be appropriately served in a home or community-based setting;

6) who elect to receive services in the alternative program; and

7) for whom the State could reasonably expect that home and community-based services would prove to be cost-effective on an individual basis over a three-year period.

The target population of the requested waiver is the same as that for the current waiver which is defined in Sections 8.400.15 b. and c. of the rules and regulations of the Colorado Department of Social Services (CDSS), Medical Assistance Staff Manual Volume 8, Long Term Care. These sections read as follows:

b. Mentally Ill/Mental Health Referral - Includes all individuals whose need for long term care is based on a diagnosis of mental disease. Mental disease refers only to those who are truly psychiatrically disabled; and does not include the chronic alcoholic, the patient with chronic dementia or the patient with organic brain syndrome. This target group includes only individuals referred by community mental health centers and clinics or state mental hospitals.

c. Mentally Ill/Private Referral - Includes all individuals as described in (b) above, but who have been referred by a private physician. Referral source category will be based on the original source of referral and will not be changed as a result of any change of status at the time the continued stay reviews are conducted.

The terms, seriously or critically and chronically mentally ill, are operationally defined in the Colorado Department of Social Services, Medical Assistance Rules and Regulations, Sections 8.509.4 i. and j. as follows:

1. Chronically Mentally Ill - For purposes of the HCB-MH, the term "chronically mentally ill" is operationally defined by the following criteria:

   Criterion A

   1. Problem Duration 1 year or longer

      and

   Criterion B (either 1 or 2 true)

   1. Has previously received inpatient, other 24-hour or partial care,
   2. Place of residence is inpatient, nursing home, intensive treatment community residence, or boarding home.

      and

   Criterion C (any two true)

   1. Current employment status is sheltered employment or unemployed for 3 months or more, or between 18 and 72 years of age and not in the labor force.
   2. Client has at least two of the following basic needs problems: food, clothing, housing, finances.
   3. Client has social skills problems.
   4. Client has self-care maintenance problems.
   5. Client has inappropriate behavior or is gravely disabled.
   6. For child/adolescent only, client has at least two of the following problems in academic/training area:
      a. absenteeism
      b. poor achievement
      c. behavior problem
      d. suspension/expulsion
      e. other academic/training problem

2. Seriously or critically mentally ill - for purposes of the HCB-MH, the terms "seriously mentally ill" and "critically mentally ill" are operationally defined by the following process which incorporates the level-of-functioning scale (LOF). The LOF scale shows the degree or amount of dysfunction in socially relevant domains. A level-of-functioning score is then determined using the Colorado Client Assessment Record, User's Guide, June 1980 to determine the client's severity. See Attachment 1.

Client is critically mentally ill if:

1. The sum of the highest three level-of-functioning ratings is equal to or greater than 100

and

2. At least one of the following problems is reported as "yes".
   - gravely disabled
   - danger to self
   - danger to others

(Note: This score may be greater than 100, but if none of the three items shown above have been reported as "yes" or if all items are blank, the client is at least "serious" as defined below).

Client is seriously mentally ill if the sum of the highest three level-of-functioning ratings is equal to or greater than 78. Client is neither seriously nor critically mentally ill if the sum of the highest three level-of-functioning ratings is less than 78.
See Attachment 2: Colorado Department of Social Services, Medical Assistance Staff Manual Volume 8, Sections 8.400.15 and 8.509.4.

The definitions for "seriously" and "critically" mentally ill reflect the response of the Division of Mental Health, Department of Institutions, to a mandate from the State Legislature in 1981 to more specifically define the "target population" served by the State's public mental health system. The state's definition of chronically mentally ill closely relates to the National Institute of Mental Health's definition of chronically mentally ill and has become the accepted standard of defining "chronically mentally ill" throughout the country.

It is important to note that these three definitions are utilized throughout the Colorado public mental health system and are not specific to the waiver request. For purposes of the requested waiver, item number one relating to employment and item number six relating to child/adolescent clients in Criterion C for the chronically mentally ill are not applicable.

B. Size of the Target Population

As discussed in the approved waiver, in November, 1981, the Division of Mental Health of the Colorado Department of Institutions completed The Study to Estimate the Number of Chronically Mentally Ill in Nursing Homes. This study used the definition of the National Institute on Mental Health community support system program population to identify residents of nursing

homes who were chronically mentally ill. Based on data collected from a sample of 1000 nursing home residents, it was estimated that 1550 out of some 17,500 nursing home residents in Colorado were chronically mentally ill.

Additionally, a survey completed in the summer of 1981 by the Colorado Department of Health examined clients enrolled in nursing homes. This survey was very close in its estimates of chronically mentally ill in nursing homes to the Division of Mental Health's estimates. When both the 1981 studies were linked, it was possible to estimate that between 700 and 900 of these nursing home residents met the test of being chronically mentally ill and were capable of being better served in other alternative settings, including intensive mental health treatment facilities, intermittent community residential facilities, boarding homes and independent living. These clients did not have significant medical barriers to placement in alternative settings.

These 700 to 900 clients and significant numbers of seriously, critically or chronically mentally ill clients in the community who were at risk of nursing home placement who were the target of the State's original waiver request. Clients with significant medical barriers to community placement were excluded from the target population based on the judgment that ICF or SNF level of care would be more appropriate in such cases and would ensure better protection of the client's health and welfare. Mental health services were made available through the existing clinic option to those clients.

According to the 1984 and 1985 Colorado Department of Health Inspection of Care surveys, the number of persons with a diagnosis of mental illness in skilled or intermediate nursing homes for the nine months ending June 1984 and June 1985, were 976 and 825, respectively. Projection of these figures to a full year basis, i.e., to October 1, 1984, and October 1, 1985, respectively, yields counts of 1305 and 1,100. Consistent with the estimate in the approved waiver, it is estimated that approximately 55 percent, or 718 of the 1984 count and 605 of the 1985 count, would fall into the target population for this waiver request. This compares to the State's unduplicated client counts of 841 and 639 for FFY 1983-84 and FFY 1984-85. The Inspection of Care counts represent the total count of persons in an ICF or SNF having a diagnosis of mental illness at the time the Inspection of Care survey was conducted for each individual home. These surveys are conducted annually over the twelve-month period from October to October.

Inspection of Care data is presented here as 1) it is the most recent, valid estimate of the number of persons in ICF or SNF facilities who have a diagnosis of mental illness and 2) it clearly supports the State's contention that the number of mentally ill persons in ICF or SNF care is, in fact, declining and that the decline is consistent with the State's estimate of the impact of the waiver on the long term care institutional population.

The State notes that, according to the June 1985 Inspection of Care survey, the total number of individuals in SNF/ICF placement having a diagnosis of mental illness (825) is seven percent of the total ICF/SNF census of 11,644.

In the State's approved waiver request for the mentally ill population, "F" or the number of target-group individuals receiving SNF or ICF services, was estimated to be approximately 55 percent of the total number of mentally ill persons in nursing homes (1550) or an estimated 850 individuals. Projections for this population used 4.3 percent or the annual growth estimate factor for all SNF and ICF clients based on the Medicaid program experience for the period 1976-1981 and were as follows:

State FY 1980-81: 850
State FY 1981-82: 887
State FY 1982-83: 925
State FY 1983-84: 964
State FY 1984-85: 1006

Converting the State's original target group estimates to a Federal fiscal year basis and projecting these estimates forward by the same 4.3 percent annually yields the following "without waiver" target population estimates:

FFY 1980-81: 859.2 (Conversion to FFY/.75 x 850 + .25 x 887)
FFY 1981-82: 896.1 (FFY 1980-81 X 1.043)
FFY 1982-83: 934.6
FFY 1983-84: 974.8
FFY 1984-85: 1016.7
FFY 1985-86: 1060.4
FFY 1986-87: 1106.0
FFY 1987-88: 1153.5

In its FFY 1983-84 HCFA-371 Report, the State estimated that it would serve an unduplicated client count of 471 in FFY 1984-85. Reducing the estimated FFY 1985-86 ICF/SNF client population of 1061 by the 471, would leave an estimated ICF/SNF target population of 590. Based on more current information, however, the State has revised its HCFA-371 estimate of the FFY 1984-85 waiver population to 382 unduplicated clients, leaving an unduplicated count of the "with waiver" target SNF/ICF population of 639.

Given the facts 1) that the Inspection of Care count clearly supports the downward trend in the number of mentally ill persons in nursing homes, and 2) that the Department of Health Inspection of Care count and the State's projected estimates based on the approved waiver are consistent, the State will continue using the baseline projections upon which the approved waiver is based for estimates of the mentally ill ICF and SNF population under the new request.

SECTION IV. DESCRIPTION OF WAIVER PROGRAM

A. State Administration

The Colorado Department of Social Services, in its role as the single State Medicaid Agency, will have prime responsibility for services authorized through the provisions of section 2176 of Public Law 97-35, the Omnibus Budget Reconciliation Act. In recognition of the State statutory responsibility placed with the Colorado Department of Institutions, however, the Departments of Social Services and Institutions will cooperatively administer the home and community-based services program for the mentally ill for which the Secretarial waiver is being sought.

House Bill 1213 of the 1985 Session of the Colorado General Assembly establishes the framework for the administrative relationship between the two departments in the administration of home and community-based services programs. See Attachment 3: House Bill No. 1213

Generally, this legislation, which became effective May 24, 1985, prescribes that the Colorado Department of Social Services promulgate those rules and regulations which are necessary to fulfill the obligations of that Department as the single State agency to administer medical assistance programs and that the Department of Institutions promulgate those rules and regulations which may be required for the fulfillment of its responsibilities to the mentally ill, as set forth in Articles 1 and 10 of Title 27, Colorado Revised Statutes. See Attachment 4. In the event a direct conflict should arise between the rules and regulations of these departments, 26-4.5-204 CRS provides that, in order to ensure that its responsibilities as the single state Medicaid agency under Title XIX of the Social Security Act will be fulfilled, the rules and regulations of the Department of Social Services will prevail.

As of this date, all rules and regulations governing the current waiver program for the mentally ill are in the Medical Assistance Rules of the Colorado Department of Social Services. A copy of this section of Medical Assistance Staff Manual Volume 8 is attached as Attachment 2. The State reserves the option of later review and possible redistribution of the administrative responsibilities for this program between the rules and regulations of the two departments.

B. Service Delivery System

Services provided through Home and Community Based Services--Mental Health, the current approved waiver program, are delivered primarily through the State's network of twenty-two community mental health centers and clinics. The State proposes to continue this service delivery system under new waiver authorization. Utilization of the existing CMHC network is viewed by Colorado as the most appropriate approach as it brings to bear an existing pool

of expert community-based mental health resources on the target population for this waiver and avoids unnecessary duplication of services.

The community mental health centers and clinics are licensed by the Colorado Department of Health and certified by the Division of Mental Health under CRS 27-1-204-205.

The current directory of Colorado's community mental health centers and clinics and a map showing the catchment area of each are attached. See Attachments 5 and 6, respectively.

C. Waiver Eligibility/Admission

1. General Requirements

As is the case with the State's approved waiver for this population, services under the requested waiver will be provided only to recipients who are not inpatients of a hospital, SNF or ICF and for whom it has been determined that the level of care provided in an SNF or ICF under Medicaid would be required in the absence of the alternative service.

The State will identify the target population for the home and community-based services program for the mentally ill by application of the following three screens:

(a) the financial eligibility requirements for Medical Assistance as assessed by the appropriate local county department of social services;
(b) the appropriate ICF/SNF level of care screen as applied by the State's Professional Review Organization (formerly Professional Standards Review Organization);
(c) the level of functioning scale, as administered and assessed by the community mental health centers and clinics.

Passing all three services eligibility screens will be required in order for services to be offered under the requested waiver. Clients meeting one or two, but not all three, of these criteria will be referred, as appropriate, for services through other human services agencies or accepted under the regular services programs of the community mental health center or clinic.

Because admission to the home and community based services program for all clients requires passing three eligibility screens which have specific verifiable criteria, the admission and screening process for diverted clients is no different than that for clients being deinstitutionalized from certified SNF's and ICF's.

2. Income Eligibility Determination

Clients served under this waiver must meet Medicaid income eligibility criteria. Colorado will offer services under the waiver to two groups of individuals:

a. Those categorically needy mentally ill individuals who are currently eligible for Medicaid services in Colorado under the approved State Plan for Title XIX;

b. Those mentally ill individuals who would be eligible for institutional services under 42 CFR 435.231 (the 300% group), and who will receive home and community-based services under this waiver. Specifically, this group includes individuals in the community who:

1) Because of their income are not eligible for Supplemental Security Income (SSI) or Colorado's Supplemental Income Payments (OAP, AND, AB);

2) Have income below a level specified in the plan under 42 CRF 435.722 (with the FFP limitation in 42 CFR 435.1005);

3) Have resources no more than the limit established by the Department of Social Services for individuals receiving the optional state supplementation of SSI benefits pursuant to state statute;

4) Would be eligible for Medicaid under 42 CFR 435.231 if institutionalized;

5) Will receive home and community-based services under a waiver granted under Part 441, Subpart G, of Title 42.

Under the provision of 42 CFR 431.10(c), the determination of financial and categorical eligibility for Medicaid is the responsibility of the State's Title IVA agency. Eligibility is determined by county departments of social services under the rules and regulations of the Department of Social Services which is the State's Title IVA agency.

Under this waiver, the local service agencies, that is, the community mental health centers, will be responsible for client intake. One element of the client intake process will be the referral of clients to county departments of social services for the determination of financial eligibility. Clients found to be Medicaid-eligible under existing provisions and criteria of this waiver will be so deemed. For clients whose income levels exceed current standards and, consequently, for whom determination of Medicaid-eligibility depends on a finding that the client is at risk of nursing home placement, the granting of Medicaid-eligibility will be pended until that risk assessment has been completed. For clients currently in nursing care facilities, financial eligibility will be redetermined prior to the actual provision of alternative services.

Colorado will handle post-eligibility treatment of income and resources (PETI) for prospective recipients of waivered services as specified in 42 CFR 435.726, which is entitled "Post-eligibility treatment of income and resources of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care." Patients falling under this category shall pay to the Department or designee, to be applied to the cost of care, an amount calculated as follows:

1) The individual's total income,
2) Less: an amount for the maintenance needs of the individual,
3) Less: an additional amount for the maintenance needs of the spouse, if applicable,
4) Less: an additional amount for other family members, if applicable,
5) Less: any amounts paid for health or medical insurance,
6) Less: amounts for incurred expenses for medical or remedial care not subject to payment by a third party, including necessary medical or remedial care recognized under State law but not covered by the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

Based on the standards for public assistance effective October 5, 1984, the Department of Social Services will use the following figures in making the calculation above:

1) Self-explanatory.

2) Maintenance needs of the individual will be calculated at the rate used for the Colorado Old Age Pension Program, that is $383.00 per month, plus any special needs supplements as specified in the approved State Plan for Medicaid.

3) If the spouse is the only dependent of the recipient, the additional amount for the maintenance needs of the spouse will be calculated at Colorado State AND level of $229; this amount will be reduced by the amount of spouses income, if any. If there are dependent children as well as the spouse, the AFDC grant level will be used (see 4).

4) If there are dependent children, the additional amount for the maintenance needs of family members will be calculated at the Colorado AFDC grant levels (an 82.37% pro-rata reduction from the AFDC need standard) as displayed on the table which follows. This amount will be reduced by the amount of other family income, if any, except types of income specified for exclusion in Colorado's approved AFDC Plan.

AFDC Grant Standard: to calculate grant standard, multiply amount below (need standard) by 82.37% and round to nearest dollar.

STANDARD OF ASSISTANCE CHART

NUMBER OF ADULTS	NUMBER OF CHILDREN										
	0	1	2	3	4	5	6	7	8	9	10	Each Additional
0		117	245	768	490	587	678	756	830	904	977	67
1	253	331	421	510	605	697	770	844	920	992	1065	67
2	357	439	533	628	716	787	861	937	1009	1082	1155	67

*Recipient can retain full income, since maintenance allowance for the recipients and family members will exceed the maximum income for eligibility under the waiver (300% of SSI standard).

5. Actual amounts paid for health or medical insurance will be calculated on an average per month basis, even if paid on another basis.

6. Self-explanatory.

Also, see Attachment 2: Department of Social Services, Medical Assistance Staff Manual Volume 8, Section 8.484.10. Patient Payment-Post Eligibility Treatment of Income. This section defines the agency responsible for PETI assessment and the process for calculation, collection and application of the PETI payments. Under the requested waiver authorization, the CMHC's, acting as the case management agency for this program, will be responsible for assessment and collection of PETI.

3. Level of Care Assessment

a. Assurance

The State of Colorado assures that it will provide for an evaluation (and periodic reevaluations) of the need for the level of care provided in an SNF or ICF, as defined by the Code of Federal Regulations, Sections 440.40 and 440.150, respectively, when there is a reasonable indication that individuals might need such services in the near future but for the availability of home and community-based services.

All clients referred to the PRO for evaluation for long term care and who are determined to have a primary diagnosis of mental illness will be referred to the appropriate community mental health center or clinic for evaluation for home and community based services for the mentally ill. All clients referred to a community mental health center or clinic for treatment and who, based on initial assessment, appear to be at risk of nursing home placement will be referred to the PRO for level of care assessment.

The State assures that reevaluations for the level of care provided in an ICF or SNF will occur at least annually and that clinical assessments of the client's mental health status will occur at intervals no greater than six months. These assurances relating to reevaluation are given based on the following procedures:

1. The Colorado Foundation for Medical Care limits the length of stay assignment for mentally ill clients receiving services in a home or community-based setting to no more than one year.

2. All home and community-based services clients will be required to have Plans of Care which have been prior-authorized by the Division of Mental Health, Department of Institutions. See Attachment 2: Colorado Department of Social Services, Home and Community Based Services--Mental Health, Sections 8.510.7 and 8.510.8.

3. A Plan of Care may not be authorized for a period of time in excess of six months.

4. Approved Plans of Care are forwarded to the State's Medicaid Management Information System where they are entered and act as a "cap" for services provided to individual clients. Home and community-based services claims will not pay without a valid prior authorization.

5. The community mental health centers and clinics are required by State statute, CRS 27-10-101 (1) (a) and (b), to treat clients in the most appropriate, least-restrictive setting. See Attachment 4.

b. New Admissions

In order to be eligible for the home and community-based services program for the mentally ill, the client must be found by the State's Professional Review Organization (PRO) to meet the applicable ICF or SNF level of care guidelines. The Colorado Foundation for Medical Care (CFMC), the State's PRO, utilizing existing protocols, will assess all individuals referred for long term care who have been determined to be Medicaid eligible or for whom an application for Medicaid services has been filed with the appropriate county department of social services, using the State's Long Term Care Admission Certification Guidelines as appropriate. See Attachment 7: Colorado Foundation for Medical Care, Long Term Admission Certification Guidelines.

c. Continued Stay

At intervals determined by the client's medical status and the length of stay assignment following the initial admission review, the Colorado Foundation for Medical Care must recertify Medicaid-eligible individuals to determine continuing medical need for the level of care provided in the ICF/SNF. The CFMC is responsible for applying the same Admission Certification Screening guidelines as applied at initial admission. See Attachment 8: Colorado Foundation for Medical Care, Procedures for Medicaid Continued Stay Review.

d. Level of Care Guidelines

The guidelines for long term care in an ICF, SNF or the home and community based services programs for the mentally ill, as established in Medical Assistance Staff Manual Volume 8, Colorado Department of Social Services, are based on a functional needs assessment in which individuals are evaluated in at least the following areas:

-Confusion
-Contact with reality
-Behavior
-Communication
-Mobility
-Bathing
-Dressing
-Eating/feeding
-Bowel continence
-Bladder continence
-Skin care
-Vision
-Hearing
-Need for supervision and observation
-Living skills (i.e., cooking, shopping, laundry, etc.)

The functional needs assessment on the Level of Care Assessment form (LTC-101) must be completed by the patient's attending physician or his properly designated representative such as a nurse practitioner. The LTC-101 must be signed by the physician. See Attachment 9: Colorado Foundation for Medical Care, LTC-101, Admission Certification Guidelines.

The PSRO must certify as to the medical necessity for the nursing home level of care. Such determinations must be based upon the professional judgement of the PRO medical advisor that the patient's condition requires the skilled and maintenance services found in a nursing home.

In order for a patient's functional needs assessment to indicate medical necessity for the skilled and maintenance services available in a nursing home, the patient must demonstrate that the frequency of need for these services exists at least on a five day a week basis.

Skilled services are those services which can only be provided by a skilled person such as a nurse or licensed therapist or by a person who has been extensively trained to perform that service.

Maintenance services are those services which may be performed by a person who has been trained to perform that specific task, e.g., a family member, a nurses aide, a therapy aide, visiting homemaker, etc. Skilled and maintenance services are performed in the following areas:

-Skin care
-Medication
-Nutrition
-Activities of daily living
-Therapies
-Elimination
-Observation and monitoring

See Attachment 2: Colorado Department of Social Services Medical Assistance Staff Manual, Volume 8, Sections 8.401.10, 8.401.17.

Also see Attachment 7: Colorado Foundation for Medical Care, Long Term Care, Admission Certification Guidelines.

4. Assessment of Mental Health Status

Certified community mental health centers and clinics are responsible for determining 1) if the individual is seriously, critically or chronically mentally ill according to the established definitions for these terms and 2) if the individual is appropriate for placement in the alternative home and community-based services program.

Clients referred from the PRO, a private physician or other agency, will be assigned to CMHC clinician who will be responsible for screening. At intake, the clinician will review key referral materials including psychiatric, medical, and psycho-social histories and functional assessments. Particular service needs and special behavior problems will be identified. The purpose of the screening process is to identify those clients who meet applicable mental health criteria. Clients passing the preliminary screening process are accepted for formal evaluation for services under the waiver.

The CMHC clinician will apply the mental health system evaluation documents PES-7A and PES-7B. See Attachment 1. The score achieved on the PES-7B determines whether a client is at least seriously, critically, or chronically mentally ill and, consequently, potentially eligible for service under this waiver. A score of at least 78 is required for a determination that the client is seriously mentally ill. The clinician, in consultation with other appropriate CMHC staff, will completely review the case and determine whether or not the client is eligible for home and community-based services.

5. Client Reevaluation

Clients provided home or community-based services will be subject to reevaluation no less frequently than every six months to re-establish eligibility under each of the three screens. This process will cover:

a) Re-determination or re-affirmation of financial eligibility of the client by the county department of social services under the established policies of the Colorado Department of Social Services.

b) Re-certification for SNF or ICF long term care by re-application by the PRO of the Admissions Certification Guidelines or re-affirmation of the status of the client in relation to the prior length of stay assignment.

c) Re-assessment of the client's mental health status, the appropriateness of the community placement and the long-term cost effectiveness of the client's Plan of Care through application of the Level of Functioning scale and clinical assessment of the client's progress by the mental health center or clinic responsible for the client under the existing Plan of Care.

In the event the client does not meet the requirements of any one of the three screens, home or community-based services will not be continued and the client will be advised of his or her rights in accordance with the Recipient Appeal Procedure for the HCB-MH Program as set forth in the rules and regulations of the Colorado Department of Social Services. See Attachment 2: Colorado Department of Social Services Medical Assistance Staff Manual Volume 8, Recipient Appeal Procedure for the HCB-MH Program, Section 8.057.50.

In the event the client meets the requirements of each of the three screens, the client will be re-certified for Continued Stay by the PRO, if necessary, and a new Plan of Care will be developed by the CMHC clinician and submitted to the Division of Mental Health, Department of Institutions (DMH/DOI) for review and prior-approval. All Plans of Care approved by the DMH/DOI shall be subject to review and approval by the Colorado Department of Social Services.

At any time, it may be determined 1) that the client may no longer be eligible for services under this waiver because sufficient improvement has been noted in client's condition to remove the client from the serious, critical or chronic range or 2) that a major change, defined as the movement of the client to a residential setting of greater or lesser service intensity, is indicated in the Plan of Care.

Termination of waivered services under this waiver will be documented on the PES-10 which documents the fact that the client's mental health status has improved to the degree that the client no longer meets the definition of seriously, critically, or chronically mentally ill. See Attachment 1, Page 9 (PES-10).

All client reevaluations or changes in status are documented on an ongoing basis in the client's case record. A major change in the Plan of Care is documented by a revised Plan of Care, approved by DMH/DOI and subject to the review and approval of the Department of Social Services.

D. Plan of Care

1. Assurance

The State assures that all services provided in the home and community-based services program for the mentally ill will be provided under a written plan of care which shall be subject to approval by the single State Medicaid Agency.

Under the current waiver authorization, the Division of Mental Health, Department of Institutions, reviews and approves all Plans of Care for clients of the Home and Community Based Services--Mental Health program. These Plans of Care are, additionally, subject to review and approval by the Colorado Department of Social Services, the single State Medicaid Agency. The State will continue this procedure under the requested authorization. See Attachment 2: Department of Social Services, Medical Assistance Staff Manual, Volume 8, Sections 8.510.6 and 8.511.

2. Definition

A Plan of Care is a coordinated plan for the provision of home and community-based services in other than a nursing home when approved by the client's physician as meeting the client's medical needs. The Plan of Care must:

a) contain a description of the services to be provided, including non-Medicaid public services as well as any Medicaid reimbursable home and community-based services;

b) establish the frequency of services provision;

c) define the duration of the service plan and a predetermined point of re-evaluation.

A physician must review and approve by signature each Plan of Care to insure that it adequately addresses the needs of the eligible person.

The Plan of Care may be negotiated for up to six months, but, in no case may be authorized for a period of time in excess of the Length of Stay assigned by the PRO.

The Plan of Care will be completed by the primary therapist, or clinician, for the individual. The medical director must approve the Plan of Care and has ultimate responsibility for total implementation of the Plan of Care. The treatment process will be monitored by both the therapist's clinical supervisor and the home and community-based mental health program manager at the community mental health center.

The Plan of Care will be incorporated into the client's treatment plan which is a plan for the provision of home and community-based services which is developed for the purpose of maximizing the client's level of functioning. The treatment plan must identify the client's problem areas and must contain measurable treatment goals specific to the identified problem areas. The treatment plan for recipients of home and community-based services must be prepared in accordance with Division of Mental Health Standards 2.14 and 3.14 Clinical/Medical Records. See Attachment 10: Department of Institutions, Division of Mental Health, Standards/Rules and Regulations for Mental Health, 2 CCR 502-2.

3. Development of the Plan of Care

For financially eligible, seriously, critically or chronically mentally ill clients who have been assessed to require SNF or ICF level of care, the CMHC clinician will develop one or more packages of alternative services to meet the particular residential and mental health services needs of the client. The clinician will also coordinate the development of the complete package of benefits and services, including any other public program benefits, such as public assistance or food stamps and, if available, community or family treatment support and assistance.

The community mental health center will be responsible for estimating the cost of client care in the alternative service program. Although only the cost of care to be provided in the period covered by the Plan of Care must be calculated, the community mental health center must provide an assessment of the long-term cost-effectiveness of the client's treatment program. The assessment of long term cost effectiveness of the client's treatment program must consist of a summary of the type and cost of the home and community-based services provided to the client from the date of the client's entry into the program to the period to be covered by the new Plan of Care and the clinician's estimate of the treatment program to be required by the client in the subsequent thirty months. See Attachment 11: Colorado Department of Institutions, Division of Mental Health, Assessment of Long Term Cost-Effectiveness.

4. Implementation of the Plan of Care

Implementation and management of the Plan of Care will be the case management responsibility of the clinical staff of the community mental health center or clinic. The CMHC staff will arrange for the specific services set forth in the Plan, monitor service delivery to ensure that the treatment program is proceeding in accordance with the Plan and maintain ongoing contact with the client. CMHC staff will be authorized to make such changes in the Plan of Care as may be required to insure the health and welfare of the client, but any change in the Plan of Care which may require a change in the prior-authorized services or which may impact the cost-effectiveness of the Plan of Care must be prior approved by the Division of Mental Health and will be subject to approval by the Colorado Department of Social Services.

When services must be provided on an emergency basis and the emergency necessitates a change in the Plan of Care, the CMHC will be required to notify the Division of Mental Health by telephone the next working day and, within five working days, to transmit a copy of the modified physician-approved Plan of Care to the Division of Mental Health for approval.

The CMHC will be required to meet the client's needs using the most cost effective methods available and, whenever possible, to secure the appropriate assistance from family, friends or other community resources.

5. Qualifications of Individual Responsible for Development of the Plan of Care

Responsibility for completion of the Plan of Care and Prior Approval form rests with the primary therapist/clinician assigned to a specific client. These clinicians are mental health center staff licensed and/or holding credentials in psychiatry, psychology, social work, psychiatric nursing or certified by the CMHC as a mental health worker based on extensive clinical training and related experience. In all instances the Medical Director for the community mental health center must approve the Plan of Care/Prior Approval.

E. Alternatives

1. Assurance

The State assures that, when a recipient is determined to be likely to require the level of care provided in an SNF or ICF, the recipient or his or her legal representative will be: (1) informed of any feasible alternatives available under the waiver, and (2) given the choice of either institutional or home and community-based services. See Attachment 2: Colorado Department of Social Services Medical assistance Staff Manual Volume 8, Long Term Care - General, 8.434.20; Recipient Appeal and Hearings, Section 8.057; and Home and Community-Based Services--Mental Health, Sections 8.509.9 and 8.510.5. See Attachment 12: Client Choice Form.

2. Process for Assurance of Client Choice

After the plan of care alternatives have been explored, the community mental health center clinician will meet with the client to explain the alternative services being offered and the client's right to choose ICF or SNF level of care. Where appropriate, the client's responsible relative or other legal representative will be asked to attend this session. Clients choosing ICF or SNF care will be referred through existing protocol to the PRO.

For clients choosing home and community-based services, the clinician will prepare a formal plan of care. The plan will be based on a more detailed treatment plan which establishes client/clinician goals and objectives which are measurable and a time frame for the accomplishment of each objective. The treatment plan is formalized in the client's clinical record.

F. Documentation of Assessment, Services, and Reassessment

The State assures that written documentation of evaluation and reevaluation will be maintained in the individual client's record. Client assessment, observations made, agreements reached, and action taken must be formalized in writing by the clinician for each individual

client as appropriate. Procedures already in place require extensive documentation in the clinical record. For the waiver, the following specific records will be maintained:

- The LTC-101
- The PES 7A and 7B
- The written statement of choice presented to clients eligible for services
- The approved, physician-signed Plan of Care
- Any documents, including the PES-10, associated with reassessment
- A revised Plan of Care, if applicable.

Client records are open to the client and/or the client's representative in accordance with state mental health standards regarding client record confidentiality.

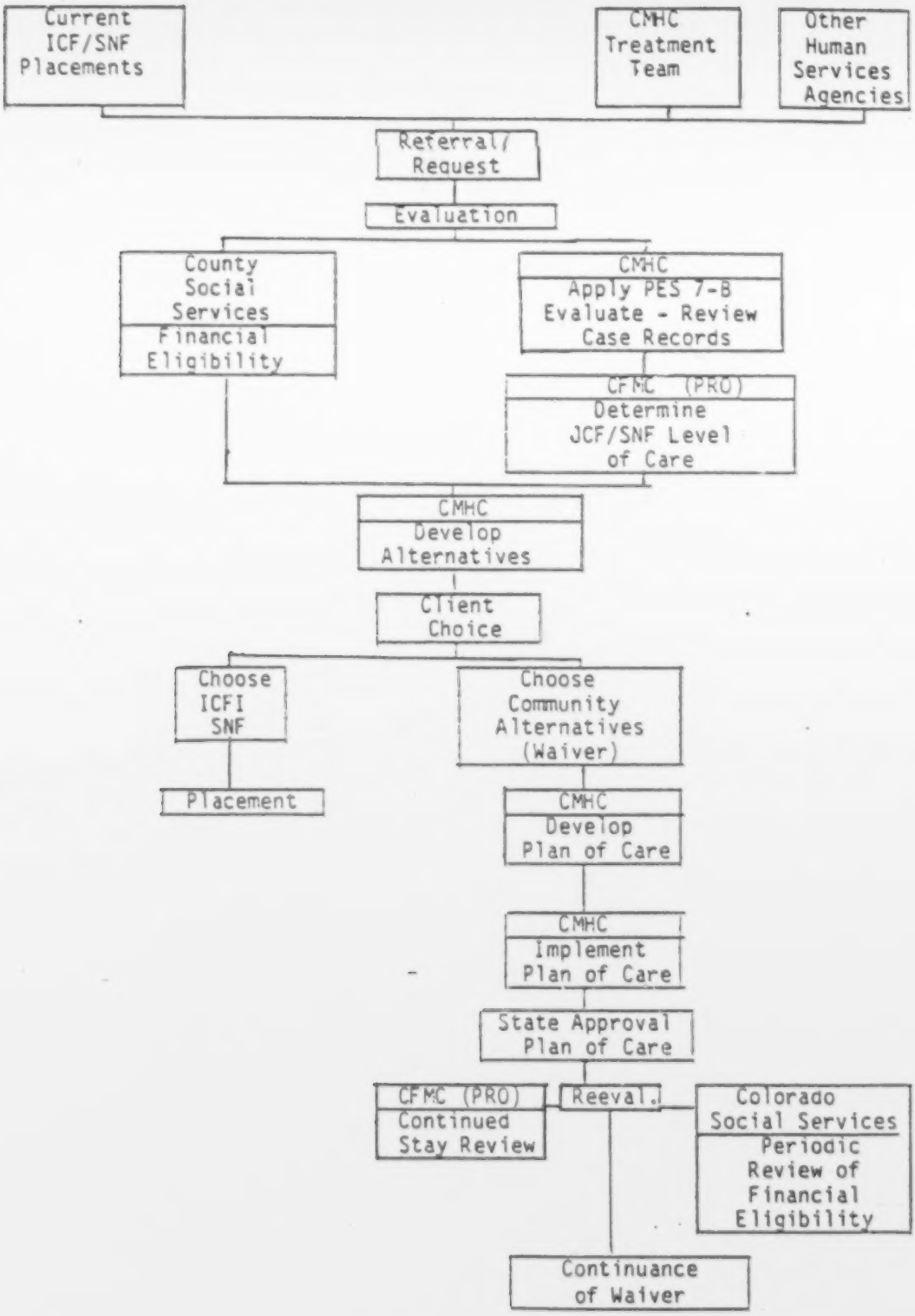
G. Intake, Referral, Admission and Reevaluation Procedures

This section describes the procedures for accepting a client for services under the requested waiver, developing and implementing a plan of care for clients accepting alternative home and community-based services, and reevaluating the need for such services. This section is summarized on the flow chart on page 26 and the accompanying "Service Responsibility Chart."

1. Initiation of Referral. Referral for services under this waiver will come from a wide variety of sources, but will principally be the following:

--Identification of clients potentially at risk of nursing home placement by community mental health staff.
--Periodic review of ICF/SNF residents in connection with the PRO Continued Stay Review.
--Referral from other human services agencies.
--Review by the PRO of all new admissions to ICF and SNF for possible referral to the mental health waiver program.

CLIENT FLOW CHART
PROGRAMS FOR THE MENTALLY ILL



SERVICE PROVISION RESPONSIBILITIES
Division of Mental Health

FUNCTION	RESPONSIBILITY (1)	DESCRIPTION
1. Initiation of Referral	1.A. ICF/SNFs	1.A. Initiate requests where client can be maintained in less restrictive settings after receiving a series of habilitative services.
	1.B. Community Mental	1.B. Initiate request for clients who will need ICF treatment.
	1.C. Referral from other	1.C. Through assessment during intake process.
2. Request	Community Mental Health	Receive request or referral of clients who appear to be eligible and at risk of nursing facility placement in an SNF/ ICF but capable of placement in alternative community services.
3. Evaluation	3.A. Social Services eligibility tech.	3.A. Determine financial eligibility
	3.B. Clinical staff at	3.B Assess medical, physical, other needs of client; apply PES-7B evaluation device.
	3.C. Colorado Foundation for Medical Care	3.C. Evaluate, through application of LTC-101, level of care requirement for ICF/SNF.
4. Develop Plan of Care Alternatives	Clinical staff at Mental Health Center	Identify alternatives available which will meet the health need of the client.
		4.A. Nursing facility
		4.B. Community-based services where a service package can meet the client's needs.
5. Client Choice	Clinical staff at Mental Health Center*	Describe to client the plan of care alternatives and assure a free choice.
6. Document Selected Plan of Care	Clinical staff at M.H.C./ approved by physician	Document the selected plan of care, including services to be provided, frequency, and type of provider.

FUNCTION	RESPONSIBILITY (1)	DESCRIPTION
7. Identify available	Clinical staff at M.H.C.*	
8. Assist client to	Clinical staff at M.H.C.*	1. Conduct pre-placement visit. 2. Assure provider & clients are mutually acceptable. 3. Finalize placement.
9. Submit Plan of Care	Approve or deny Plan of Care at DMH	DMH reviews Plan of Care for appropriateness and cost effectiveness.
10. Reevaluation of & Service Needs. Revisions to Plan of Care	Clinical staff at M.H.C./* approved by physician	Reevaluation at least every six months of client's needs, ability of current plan of care to meet those needs; alternatives available; document and implement changes in assessment of plan of care.
11. Reevaluation of &	Clinical staff at M.H.C./*	Reevaluation at least every six months of client's needs, ability of current plan of care to meet those needs, alternatives available; document and implement changes in assessment or plan or care.

All steps to be periodically audited by the Division of Mental Health.

*The community mental health center as the provider, designates those individuals within its staff, who by reason of training and experience, are qualified to develop the plan of care. The center/provider is responsible for the performance of its clinicians. A physician, licensed in the State of Colorado, must formally approve the Plan of Care and any substantive changes.

In addition, each CMHC must comply with the following requirements concerning medical necessity:

1) A physician will review each Medicaid patient either in person or in conference with the treating therapist prior to the submission of the first billing statement and at least every six months thereafter. Please note the following requirements continue:
   a) Patients who are on medication must be seen by a physician at least every three months. See Attachment 10: Department of Institutions, Division of Mental Health, Standards/Rules and

Regulations for Mental Health revised November, 1981, Center Standard 2.16.1 and Clinic Standard 3.16.2.

b) Patients who were certified under C.R.S. 27-10 provisions must be seen at least monthly by a physician.

2) The physician note at admission and the regularly scheduled six-month reviews will include the diagnosis, the medical necessity of treatment being initiated, and review of the content of the treatment plan. The attached Medical Necessity Form will be used for this purpose. See Attachment 13.

SECTION 4. PROPOSED WAIVER SERVICES

Services Package

is requesting a Secretarial waiver to provide the services:

Management
onal Care
naker Services
ite Care
nedical Transportation

ing or delivery of a particular service or combination of will be based on the following criteria:

Each service is approved as a home and community-based service by a Secretarial waiver under Section 1915 (c) of the Social Security Act.

The services are provided under a Plan of Care which has been approved by the Division of Mental Health, Department of Institutions and which is subject to review and approval by the Colorado Department of Social Services.

The providers of the authorized services are appropriately licensed or certified in accordance with applicable State requirements.

The client has been determined to meet all eligibility requirements of the home and community-based services program.

of Colorado proposes to provide the authorized waiver requested above in four types of community-based settings:

Intensive Community Treatment Facility
Intermittent Community Treatment Facility
Independent Living Settings, including private home or apartment, adult foster care facilities or board and care facilities
Respite Care Settings, including a CMHC licensed facility or a nursing home licensed by the Colorado Department of Social Services.

in an Intensive or Intermittent Community Treatment involves structured residential care with an emphasis on alth services. Residential care is defined as the of community-based residential services for the , critically or chronically mentally ill who require a f 24-hour supervision, monitoring of medications and e care in order to be removed or diverted from ICF or SNF care.

Residential care may be appropriate for chronically mentally ill clients with severe mental disabilities who have been diagnosed as having a schizophrenic, major affective or paranoid disorder, or other severe mental illness with a documented history of persistent psychotic symptoms.

* The requested package of waiver services reflects the continuum of care concept upon which the Colorado mental health system is developed. The costs for the two intensities of residential care are expected to be, on a daily rate basis, higher than the costs of ICF or SNF nursing home care. Alternative residential care, however, with an effective mental health treatment component is expected to permit clients to move rapidly into less intensive and less costly settings in a manner which will prevent recurrence of the conditions that led to institutionalization or risk of institutionalization. The proposed service structure is clearly based on the premise that intensive services provided early on will result in long-term cost avoidance. Considered from this broad systems perspective, the utilization of intensive treatment is more cost effective than maintenance of a client indefinitely in a nursing care facility which does not have a mental health services orientation.

In addition, while such costs are not a proper subject of this waiver request, the provision of these types of services also avoids inpatient hospitalization costs in both public and private facilities, significant portions of which are underwritten by Medicaid. In particular, the State has noted several instances in which nursing home patients have resumed such hospitalization for significant periods of time on a recurring basis.

Services to be offered in the Intensive and Intermittent Community Treatment Facilities include:

--Case Management,
--Personal Care, and
--Non-Medical Transportation.

The State will reimburse for this package of services in a "bundled" or omnibus rate. In accordance with the provisions of CFR 42 441.310 (3), the rate will exclude the cost of room and board which is defined to mean three meals a day and shelter. Providers of Intensive and Intermittent services will be required to follow principles]es of cost accounting to segregate the cost of room and board from the cost of the approved waiver services provided in these facilities.

Services to be provided to clients in the independent living settings are:

--Case Management,
--Personal Care,
--Homemaker Services, and
--Respite Care. *

For the independent-living population, case management and, in some cases, respite care will be provided by the community mental health centers and clinics. Personal care, homemaker services and respite care--when provided in an ICF or SNF facility--will be provided by individuals, agencies or facilities licensed by the Colorado Department of Social Services for such purposes. The State notes that personal care is defined differently for the independent living population than for those individuals in the Intensive and Intermittent Residential Facilities.

B. Relationship of Waiver Services to Medicaid Clinic Option Services

In its approved waiver for this population, regular Medicaid clinic services as authorized by 42 CFR 440.90 were included as a part of the waiver services package. With the March 13, 1985, revision of CFR 440.180 (a) to define home and community-based services as a service not otherwise furnished under the State's Medicaid plan, Colorado has removed clinic services from the waiver service package, but will continue to provide these services to the waiver population as may be required, including the cost of these services in D' of the cost effectiveness equation, rather than in D as is the case with the approved waiver.

Because Medicaid clinic option services to clients deinstitutionalized or diverted from ICF or SNF placement will be increased beyond that which would have been provided to this population in the nursing home setting, it is the State's intent to continue inclusion of Medicaid Clinic Option services in the waiver client's Plan of Care and to prior authorize such services, even through they are no longer a waiver service.

Treatment of Medicaid clinic option services in this manner is consistent with the State's policy relating to the provision of Home Health Care to home and community-based services clients. Because Home Health Care would only be required by the client by virture of the fact that the client was no longer in--or had been diverted from--a nursing home, the State, as a part of its Medicaid cost containment practices, has prior authorized Home Health Care for all Colorado's waiver populations. Because, however, the cost of skilled home health care added to the cost of Medicaid Clinic Option services, as well as any other home or community-based services, would, in almost all instances, significantly exceed the cost of ICF or SNF care or impair the cost-effectiveness of this program, it is not expected that mentally ill clients who are also in need of Home Health Care would meet the cost effectiveness requirements of this program and, consequently, no estimate home health care is included in the equation.

C. Description of Waiver Services

1. Case Management

Definition: Case management services are those services performed by staff of the community mental health center or clinic for a home and community-based services client which includes responsibility for reviewing cases, setting treatment

goals, designing treatment plans, developing and coordinating the necessary components of the client's Plan of Care, calculating the cost effectiveness of the Plan of Care, monitoring the treatment and retaining responsibility for the enrolled client's treatment. Case management responsibilities include the following tasks:

a) Determining the eligibility of an individual referred to the CMHC for assessment for placement in the home and community-based services program for the mentally ill or identified by the CMHC as being at risk of institutionalization in an SNF or ICF facility;

b) Assessing the feasibility of diverting the individual from SNF or ICF placement by development of treatment goals and treatment plans for such individual and a Plan of Care for placement of the individual in an alternative community-based program;

c) As appropriate, involving the individual or the legal representative of the individual in the development and implementation of the Plan of Care and, as appropriate, involving family members and cooperating with other community service agencies in the development and execution of the treatment program for the individual.

d) Advising the individual of the choice of ICF or SNF care or alternative home and community-based services which are available and appropriate to the needs of the client and of the rights of the individual in relation to services offered or denied;

d) Submitting the Plan of Care to the Division of Mental Health, Department of Institutions, for review and approval and implementing the approved Plan of Care;

e) Monitoring of the provision of services under the Plan of Care and initiating of reassessment of the client and re-determination of eligibility prior to the expiration of the Plan of Care or upon indication of a significant change in the condition or status of the individual;

f) Evaluating the effectiveness of the services provided and estimation of the cost-effectiveness of the Plan of Care and the long term treatment program;

Providers: Licensed community mental health centers and clinics certified as providers of home and community based services shall provide all case management services under the requested waiver authorization.

Reimbursement: Reimbursement for case management services will be made on a unit cost basis with a maximum of 180 units to be provided to a full year equivalent client.

2. Personal Care

Personal care services to be provided in the home and community based services program for the mentally ill are of two types--those provided as a part of the "bundled" rate in the Intensive and Intermittent Community Residential Facilities and those provided to waiver clients in independent living settings.

a. Personal Care in Intensive and Intermittent Community Treatment Facilities

Definition: Personal Care services provided in an Intensive or Intermittent Community Based Treatment Facility are those health and social services, both direct and supportive in nature, necessary to provide for the optimum functioning of the client.

Personal care services provided in Intermittent Community Treatment Facilities will be distinguished from personal care services provided in Intensive Community Treatment Facilities by their emphasis on peer support and by the provision of less than 24-hour on-site supervision by skilled mental health professionals.

Personal care activities are directed toward the following types of care and skill development:

Basic Care Skills--Those skills and abilities which would allow individuals to obtain their basic needs with respect to food, clothing, transportation, housing, finances and other problems caused by the lack of opportunities and/or resources in the client's environment.

Self Care Management--Those skills and abilities which would allow an individual to meet basic needs with respect to personal hygiene, diet, budget, use of leisure time and other personal affairs, preparation of food, and upkeep of residence and clothing.

Social Skills--Those skills and abilities which would allow an individual to interact with others in a constructive manner.

Recreation/Socialization Activities: Services intended to avail clients of therapeutic activities intended to improve their functional abilities in the social, mental physical and emotional spheres. These activities are designed to enhance the client's skills in time-management by providing guidance in planning and utilizing their leisure time, either independently or in socializing with others.

Providers: Personal care residential services will be provided by staff of the community mental health center or clinic or may be subcontracted by the community mental health center or clinic with a provider certified by the Department of Social Services.

Reimbursement: Personal care services in the Intensive and Intermittent Community Residential Treatment Facilities will be reimbursed on a prospective daily rate basis as a part of the "bundled" rate for these facilities. This rate shall include case management, personal care and non-medical transportation. The rates for Intensive and Intermittent services shall not include room and board.

b. Personal Care for Clients in Independent Living Settings

Under the State's existing waiver for the mentally ill population, the provision of personal care is limited to clients in one of the residentially-based settings. The State's experience to date with the HCB-MH client population residing in independent living settings strongly indicates that a portion of this population requires additional support with personal care and homemaking activities in order to maintain themselves in independent living situations. Although this type of care can currently be obtained for the most severe of this sub-population through the Home Health Care program, if the recipient is additionally in need of skilled nursing care, the addition of personal care and homemaker services to the waiver services package would provide a less costly option for unskilled care and would permit this type of service to be provided when skilled nursing care is not essential.

The State is, therefore, seeking authorization to provide to eligible clients in independent living a different type of personal care than that which is currently authorized for HCB-MH clients in Intensive or Intermittent residential treatment programs. For the three-year period to be covered by the extended waiver, it is estimated that approximately one-fourth of the unduplicated client population may require personal care and/or homemaker service.

Service definitions, provider requirements and reimbursement for personal care for waiver clients in independent living settings are as follows:

Definition: Personal care means services furnished to a recipient in his or her home and which are provided for the purposes of meeting a recipient's physical requirements and/or accommodating a recipient's maintenance or supportive needs.

Personal care services may include:

(a) Basic personal tasks such as bathing, hair care and assistance with dressing.

(b) Assistance with medications which are ordinarily self-administered when ordered by the patient's physician.

(c) Household services if related to a medical need and essential to the patient's health and comfort in his home including rearrangement of furniture to enable freer mobility for the patient in his home, changing of bed linens, cleaning of a specific living area when the patient occupies that room to a great degree.

(d) Assistance with bladder and/or bowel requirements

(e) Assisting the patient to and from the bathroom.

(f) Assisting the patient with bed pan routines.

(g) Assistance with food, nutrition and diet activities including the preparation of meals, when required, if incidental to a medical need.

(h) Accompanying the patient to the clinic or physician office or on trips to service providers which are made for the purpose of obtaining treatment or meeting needs established in the case plan.

(i) Laundering of recipient's bed clothing and bedding that is incidental to the care of the patient.

(j) Shopping for groceries or household items specifically necessary for the health and maintenance of the patient.

Providers: Providers shall be agencies which meet State certification standards established for personal care services and selected by the community mental health center HCB-MH case manager. See Attachment 2: Colorado Department of Social Services, Medical Assistance Volume 8, General Certification Standards, 8.487.10.

Reimbursement: Reimbursement for personal care services furnished by certified providers will be made for prior authorized services for one-half hour units of service.

3. Homemaker Service

Definition: Homemaker services shall mean services provided to a recipient in the home setting in order to maintain a healthful and safe environment.

Homemaker services shall include, but not be limited to:

(a) general household activities including preparation of meals;

(b) routine household care and teaching;

(c) demonstrating and providing household management techniques that promote self care, independent living and nutrition;

(d) incidental personal care.

Providers: Providers of homemaker services provided to HCB-MH recipients shall conform to all standards for such services established by the Colorado Department of Social Services for such services. See Attachment 2: Colorado Department of Social Services, Medical Assistance Volume 8, General Certification Standards, 8.487.10.

Reimbursement: Reimbursement for homemaker services shall be made for prior authorized services for one-half hour units of service.

4. Non-Medical Transportation

Definition: The non-medical transportation program will offer transportation services, such as taking the client to and from the social security office, assisting the client in gaining access to necessary community services, such as low income housing, visiting proposed community residential settings, picking up prescriptions, etc. The goal of such services is to ensure that clients have sufficient mobility in order to function successfully in a non-institutional setting. We will offer transportation services which are necessary to implement the plan of care by providing access to clinical and other required supportive services.

Providers/Reimbursement: Non-medical transportation will be provided only by CMHC's or sub-contracted with licensed/certified providers. Reimbursement will be made through the "bundled" rate for Intensive and Intermittent care.

5. Respite Care

Definition: Respite services are those of a short-term nature provided to individuals temporarily to relieve the individual's family or other home provider for unforeseen emergencies and/or the daily stresses and demands of caring for that individual. The intent of this service is to avoid the need for institutional care by providing for necessary relief for the client's primary care giver. Respite care services will be provided only to individuals in independent living

where the need to provide such services is necessary to permit the primary care giver (member of the natural family or other individual) relief from the demands of client care or to the care giver to attend to emergencies or other unforeseen events. Respite care services are viewed as integral to the success of the continuum of care concept, particularly where the goal of such services is reestablishment of the natural family support system. That process, particularly in its early stages, is strengthened by providing relief from the demands and tensions associated with reintroducing the individual into the natural family.

Providers/Reimbursement: The State intends to utilize nursing homes or facilities of the community mental health center or clinic for the provision of respite care. Respite care services will not exceed 30 days for any particular client in a one-year period and are expected to average 20 days for a relatively limited number of total clients. Respite care services will be reimbursed in accordance with the reimbursement for nursing homes, i.e., on a daily basis the lower of actual cost or the average weighted rate for administration and health care for Class I SNF or ICF nursing homes in effect on July 1 of each year minus the average weighted costs for the following costs: travel and entertainment, pharmacy, medical supplies, laboratory and x-ray.

SECTION VI: PROVIDER STANDARDS/CERTIFICATION

A. Assurances

The State of Colorado assures HCFA that necessary safeguards have been taken to protect the health and welfare of the recipients of the services. These safeguards include adequate standards for all types of providers that provide services under the waiver.

The State of Colorado assures HCFA that the standards of an State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver.

B. Community Mental Health Centers and Clinics

Community mental health centers and clinics which have contracted with the Division of Mental Health of the Colorado Department of Institutions and which, consequently, conform to the Standards/Rules and Regulations for Mental Health issued by the Department of Institutions pursuant to applicable sections of the Colorado Revised Statutes will serve as primary providers under this waiver request.

In order to provide waiver services, a CMHC must be in compliance with the following:

1. Standards/Rules and Regulations for Mental Health, revised November, 1981. See Attachment 10.

2. Clinical Quality Assurance Guidelines for Clinical Care, Reviews and Review Examples, March, 1980. See Attachment 14.

3. Care and Treatment of the Mentally Ill, Rules and Regulations, July 30, 1984. See Attachment 15.

4. Accounting and Auditing Guidelines, May 1, 1983.

5. Standards for Residential Care Facilities for the Mentally Ill (RCF-MI). See Attachment 16.

The Standards/Rules and Regulations set forth administrative, personnel, clinical services, and medical practice procedures and regulations for the State's community mental health system, primarily the community mental health centers and clinics.

Attention is drawn particularly to the following provisions of the Standards/Rules and Regulations for Mental Health as particularly relevant to this waiver request:

- Standard 2.6: Qualifications of Center Director
- Standard 2.9: Personnel Policies and Employment Records
- Standard 2.11: Facilities Standards, Management, and Maintenance

- Clinical Standards: Standards 2.13 through 2.23
- Standard 2.18: Patient Rights
- Standard 2.15: Quality of Patient Care and Treatment
- The parallel standards for clinics generally in part 3
- Standard 2.3: Affiliated Services and Agreements
- Standard 2.7: Financial and Statistical Data Systems

CMHC's will be authorized to provide directly or to contract with other certified service providers to provide transportation, personal care, homemaker and respite care services. The decision to contract for such services will rest with the responsible CMHC and will be a function of CMHC capability, cost effectiveness, and reimbursement restrictions of this waiver. Should services be contracted, CMHC's must certify that the standards incorporated into the contracts generally conform to the standards/rules and regulations that apply to CMHC's themselves.

In addition each CMHC will be approved by the Colorado Department of Social Services as an approved Medicaid provider of the waivered services. The CMHC's are currently recognized in the State's Medical Assistance Plan as certified providers for clinic option services.

All CMHC's are currently licensed by the Colorado Department of Health under the licensing category of community mental health centers and clinics. As the state agency having the authority to regulate all health facilities in Colorado, all CMHC's must be approved by the Department of Health. This is accomplished only after the Division of Mental Health has approved each center annually as being in compliance with items 1. through 4. as set forth on the previous page.

Services which will be provided by the community mental health centers and clinics are the following:

Case Management
Personal Care
Non-Medical Transportation
Respite Care

These services will be provided to eligible clients in residential settings and in independent living settings. For the residentially based services, case management, personal care and non-medical transportation will be bundled in a daily unit-cost rate. These services will be termed Intensive and Intermittent Community Treatment facilities. In order to provide the Intensive and Intermittent services, the CMHC's must obtain a Residential Care Facility License for the Mentally Ill from the Colorado Department of Health. See Attachment 16: Colorado Department of Health, Residential Care Facilities for the Mentally Ill, Section VII.

Those CMHC's providing Intensive and Intermittent services must also be approved by the Division of Mental Health as certified providers of these services. In order to approved, the CMHC must submit documentation and materials demonstrating compliance with Standards/Rules and Regulations for Mental Health, Clinical Quality

Assurance Guidelines and rules governing the Care and Treatment of the Mentally Ill; must provide an adequate description of the program and services to be provided; and must meet the appropriate Department of Health facility standards, i.e., the standards for Residential CAre Facilities for the Mentally Ill, and applicable local ordinances and zoning.

At a minimum, in order to be certified as an Intensive and/or Intermittent provider of service, the CMHC must address each item of Section 8.510.23 (d) (1) (a) (b) (c) for Intensive Services and/or Section. 8.510.23 (d) (2) (a) (b) (c) of the Colorado Department of Social Services, Medical Assistance Staff Manual Volume 8.

C. Nursing Homes:

Nursing homes may provide respite care for those clients in independent living when such services have been prior authorized by the Division of Mental Health, Department of Institutions. Nursing homes are licensed by the Department of Health. See Attachment 17: Colorado Department of Health, Nursing Care Facility, Chapter V; and Attachment 18: Colorado Department of Health, Intermediate Health Care Facility, Chapter VI. The Department of Health conducts site visits to each nursing home on a regular basis to ensure that each facility is in compliance with these requirements. These standards address issues concerning the administrative, programmatic and quality of care of the specific nursing home.

In addition, each nursing home must be in compliance with the Rules and Regulations for the Colorado Department of Social Services. (Staff Manual, Vol. 8, Section 8.405 through 8.406.2 and 8.420.) Nursing homes licensed by the Colorado Department of Social Services and the Colorado Department of Health and participating in the State's Medicaid program will be utilized only for respite care under this waiver. Each of these facilities by virtue of being licensed certified Medicaid providers under the State Medicaid Plan will have demonstrated compliance with all applicable state and federal rules and regulations governing such facilities.

D. Personal Care/Homemakers

Individuals participating in the waiver are eligible to receive personal care and homemaker services provided by agencies certified by the Colorado Department of Social Services. Providers of these services shall be certified by the Colorado Department of Social Services as meeting the General Certification Standards. See Section 8.487.10 of Attachment 2. These standards include mandates for specific service providers, content of client records, provisions for confidentiality, billing procedures and financial records, provision of adequate training for care givers, policies and procedures for staffing and compliance with Title II of the Civil Rights Act of 1964 (PL 88--352).

SECTION VII: FACILITY STANDARDS

A. Assurance

The State of Colorado assures HCFA that all facilities covered by section 1616 (e) of the Social Security Act, in which home and community-based services will be provided, will be in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

B. Discussion

All HCB-MH clients receiving either of the residentially-based services approved under the requested waiver, i.e., either Intensive or Intermittent Community Treatment, will reside in facilities covered by standards for Residential Care Facilities for the Mentally Ill.

In October 1984, the previously existing standards for residential care facilities in which mentally ill persons were served were revised to assure appropriateness for the mentally ill target population. See Attachment 16: Colorado Department of Health, Residential Care Facilities for the Mentally Ill, 6 CCR 1011-1, Chapter XIII (2).

No home and community-based services will be provided to waiver clients in independent living settings in the facility in which they reside unless the residential facility meets applicable State or local standards for adult personal care boarding homes or is licensed as an Adult Foster Care facility. Case management services will be provided to HCB-MH clients at the certified community mental health center or clinic. See Attachment 19: Colorado Department of Social Services, Medical Assistance Staff Manual Volume 7, Adult Foster Care Regulations.

It is unlikely that Home Health Care would be provided to any client enrolled in the home and community-based services program for the mentally ill because of the cost-effectiveness limitations of the program; however, any Home Health services provided to this population would be prior authorized by the State through the HCB-MH program. Although Home Health Care is not a waiver service, but a regular service of Medicaid under the State Plan, the State, nevertheless, assures that it will not prior authorize Home Health Care for HCB-MH clients who reside in facilities which are covered by the requirements of 1616(e) and which are not in compliance with applicable State or local standards.

Any HCB-MH clients receiving respite care services in a community mental health center or clinic facility or in a nursing home would be covered by standards for Residential Care Facilities for the Mentally Ill or Nursing Care Facility Standards of the Colorado Department of Health, respectively. See Attachments 17 and 18: Colorado Department of Health, Nursing Care Facility, Chapter V and Intermediate Care Facility, Chapter VI.

SECTION VIII: COST EFFECTIVENESS

A. Assurances

The State of Colorado assures that:

1. The average per capita fiscal year expenditures under the waiver will not exceed the average per capita expenditures for the level of care provided in an SNF or ICF under the State Plan that would have been made in that fiscal year had the waiver not be granted.

2. The State's actual total expenditures for home and community-based services under the waiver and its claim for FFP in expenditures for the services will not exceed the State's approved estimates for these services, expressed as the product of (C x D) in the supporting documentation required under Section 441.303 (f), for each year of the waiver period.

3. The State's actual total expenditures for home and community-based and other Medicaid services provided to individuals under the waiver will not, in any year of the waiver period, exceed the amount that would be incurred by Medicaid for these individuals in an SNF or ICF in the absence of the waiver.

In documentation of these assurances, the following sub-sections 1) explain the derivation of the State's estimates of Medicaid utilization and expenditures for the target population of this waiver request for the three-year period from October 1, 1985, to October 1, 1988; 2) show the calculation of the estimated expenditures for home and community-based services; and 3) demonstrate the cost-effectiveness of the proposed program by application of the estimates to the cost-effectiveness equation.

B. Derivation of Estimates

Except for the deletion of Medicaid clinic option services as a waiver service and the addition of very limited personal care and homemaker services for approximately one-fourth of the proposed waiver population, the State is basically seeking authorization to continue the current HCB-MH program which was authorized January 6, 1983, retroactive to October 1, 1982.

TABLE I, therefore, presents the State's estimate of clients and expenditures for the final year of the current waiver program (FFY 1984-85) as presented on the State's Second Annual HCFA-371 Report, updates the HCFA-371 estimate based on more current information and, finally, adjusts the revised FFY 1984-85 estimates for each

TABLE I
CONVERSION FROM CRITERIA TO FINAL
COST-EFFECTIVENESS FORMULA
FOR APPROVED WAIVER

WAIVER REQUEST:
ESF 441.300 (
FFY 1985-86 -- FFY 1987-88

3485222A

WAIVER FACTOR	DEFINITION OF FORMULA FACTOR	EST FROM 83-84 HCFA-372	REVISED ESTIMATE FFY 1984-85	ADJUSTMENT TO NEW FORMULA CALCULATIONS	EXPLANATION	BASE HCBS/ICF FORMULA
A	The estimated annual number of beneficiaries who would receive the level of care provided in an SNF or ICF with the waiver.	546	625	No Change		625
B	The estimated Medicaid payment per eligible Medicaid user of such institutional care.	3088	8319		Includes $6,745 SNF ICF average cost plus $1,574 Nursing Home Clinic Option ICF 83-84 x 1.0287	
B REV	The estimated annual Medicaid expenditure for SNF or ICF care per eligible Medicaid user with the waiver.	0		$8,319 less $1,574 Clinic Option Nursing Home Costs	New formula restricts B to SNF or ICF care. SNF/ICF case = FFY 1983-84 HCFA-372 Actual x 1.08% annually	6745
C	The estimated number of beneficiaries who would receive home and community-based services under the waiver or other non-institutional alternative services included under the State plan.	1021		550 + 382 = 932	Includes estimated 382 clients receiving home and community-based services plus 550 receiving non-institutional long term care services	
C REV	The estimated annual number of beneficiaries who would receive home and community-based services under the waiver.	0		932 less 550 estimated clients receiving non-institutional long term care = 382	New formula restricts C to home and community-based services	382
D	The estimated annual Medicaid expenditure for home and community-based services per eligible Medicaid user.	4004		$4,089,070 - $1,064,250 = $3,027,790/471 = $6,429 (Client estimate adjusted based on more current data	From 2nd Year HCFA-372 FFY 1984-85 Estimate of D less non-institutional long term care Includes Clinic Option Waiver Services, based on approved Plans of Care	6421
F	The estimated annual number of beneficiaries who would likely receive the level of care provided in an SNF or ICF in the absence of the waiver.	1017		No Change		1017
B	The estimated annual Medicaid expenditures per eligible	3088	8319		Includes $6,745 SNF ICF average cost plus $1,574 Nursing Home	6745

	Medicaid user of such institutional care in the absence of the waiver.			Clinic Option (FFY 87-94 = 1.03%)	
H	The estimated annual number of beneficiaries who would receive any of the noninstitutional, long-term care services otherwise provided under the State plan as an alternative to institutional care.	550			550
I	The estimated annual Medicaid expenditure per eligible Medicaid user of the non-institutional services referred to in H	1935	$1,764,280/550 from HCFA-372	Revised estimate from $1,872 to $1,930 based on change from 1.05% increase used in HCFA-372 to 1.03%	1930
J	The estimated annual number of beneficiaries referred to in H who would receive any of the acute care services otherwise provided under the State plan.	0	220	Assumes that all beneficiaries referred to in H could feasibly require acute care services	220
J'	The estimated annual Medicaid expenditure per eligible Medicaid user of the acute care services referred to in J'.	0	(FFY 1987-94) $7,070 cost per client. Total acute care costs less Long Term Care	Based on sample of 22 nursing home clients receiving clinic option services. From April 1985 SLRS run for FFY 1987-94 FFY 1994-95 = $7,070 x 1.03%	7216
C'	The estimated annual number of beneficiaries referred to in C who would receive any of the acute care services otherwise provided under the State plan.	0	282	Assumes that any beneficiary referred to in C could feasibly require acute care services.	282
D'	The estimated annual Medicaid expenditure per eligible Medicaid user of acute care services otherwise provided under the State plan.	0	(FFY 1987-94) 2877	From Schedule B of HCFA-64 FFY 1987-94 HCFA-372 report FFY 1994-95 = $2,877 x 1.03% FFY 1995-96 = $2,792 x 1.03%	2792
F'	The estimated annual number of beneficiaries referred to in F who would receive any of the acute care services otherwise provided under the State plan.	0	1017	Assumes that any beneficiary referred to in F could feasibly require acute care services	1017
G'	The estimated annual Medicaid expenditures per eligible Medicaid user of the acute care services referred to in F'.	0	(FFY 1987-94) $7,070 cost per client. Total acute care costs less Long Term Care	Based on sample of 22 nursing home clients receiving clinic option services. From April 1985 SLRS run for FFY 1987-94 FFY 1994-95 = $7,070 x 1.03%	7216

factor of the interim cost-effectiveness formula to meet the requirements of the equation as published in the March 13, 1985, Federal Register.

All "with" and "without" waiver costs are inflated by a factor of 8 percent which is derived from the historical trend of long term care costs as reflected on the State's HCFA 2082 reports for the period from 1981 to 1984. See Attachment 20: Colorado Department of Social Services, Division of Aging and Adult Services (AASD), Analysis of HCFA-2082 Reports, FFY 1981-84.

This request for authorization to provide home and community-based services to mentally ill beneficiaries is limited to those who would receive the SNF or ICF level of care. Only a limited number of long term care mentally ill persons would be served in the ICF-MR level of care and, as it is assumed that these clients would be diagnosed as both mentally retarded and mentally ill, they could not be appropriately served in the HCB-MH program. The ICF-MR level of care is, therefore, excluded from this request.

Based on the Colorado State Survey Agency Title XVIII and Title XIX Budget Request dated September 19, 1984, the total number of certified Skilled Nursing Facility beds in the State of Colorado was 15,165. The total number of certified Intermediate Care Nursing Facility beds was 1,684, yielding an unduplicated total SNF/ICF bed count of 16,849 as of October 1, 1984. Of this number, the target population for the home and community-based services program for the mentally ill is estimated to be 1,061 by Federal Fiscal Year 1985-86, with 397.6 long term care clients expected to be served in home and community-based services settings. See Section III of this request for additional data relating to the ICF/SNF mentally ill target population.

A conservative normal growth factor of 4.3 percent, the annual growth factor for all SNF and ICF clients based on Medicaid program experience for the period from 1976-1981, is applied to the long term care target population for this waiver.

The "Without Waiver" factors are estimated as follows:

F The estimated annual number of beneficiaries who would be likely to receive the level of care provided in an SNF or ICF in the absence of the waiver has not changed from the figures presented in the approved waiver. The estimate, therefore, is based on the original Federal Fiscal Year estimate of 859 clients, with an annual growth rate of 4.3 percent, i.e.:

FFY 1980-81	859
FFY 1981-82	896
FFY 1982-83	935
FFY 1983-84	975
FFY 1984-85	1017
FFY 1985-86	1060
FFY 1986-87	1106
FFY 1987-88	1154

G The estimated Medicaid expenditure per eligible Medicaid user of such institutional care in the absence of the waiver is derived from the State's FFY 1983-84 HCFA-2082 report and is calculated as follows:

	ICF Column (7)		SNF Column (8)	
	Recipients	Expenditures	Recipients	Expenditures
HCFA 2082	9751	$68,329,188	5272	$29,537,254
Less ICF-MR clients in SNF setting	-0-	-0-	(77)	(1,741,621)
	9751	$68,329,188	5195	$27,795,633

Total Recipients = 9751 + 5195 = 14,946

Total Expenditures = $68,329,188 + $27,795,633 = $96,124,821

FFY 1983-84 Average Cost Per Recipient = $6,431.47

The reduction of SNF recipients and expenditures reflected in this calculation is in accordance with the calculation of cost per client as presented in the State's Second Annual HCFA-371 Report for Home and Community Based Services for the Developmentally Disabled (HCB-DD)--the companion program to the HCB-MH program. See Attachment 21: State of Colorado, Excerpt from HCB-DD FFY 1983-84 HCFA-371 Report, pages 3.3 through 3.6.

FFY 1985-86 ICF/SNF cost is a projection of the FFY 1983-84 cost of $6,431.47, i.e.:

FFY 1984-85 = $6,431 x 1.08%, or $6,945
FFY 1985-86 = $6,945 x 1.08%, or $7,501
FFY 1986-87 = $7,501 x 1.08%, or $8,101
FFY 1987-88 = $8,101 x 1.08%, or $8,749

H The estimated annual number of beneficiaries who would receive any of the non-institutional, long-term care services otherwise provided under the State plan as an alternative to institutional care is derived from the approved waiver. In the approved waiver, H is defined as the estimated number of clients in independent living or boarding homes who might otherwise be in nursing home placement but for the provision of clinic option services. The State estimated that 20 percent of all clinic option services were attributable to clients who would be in SNF or ICF nursing care in the absence of the clinic option care. For State Fiscal Year 1982-83, H was, therefore, estimated at 500 clients. The base estimate for SFY 1982-83 has been converted to a federal fiscal year basis and carried forward with an estimated annual increase of 4.3 percent.

H is calculated as follows:

SFY 1982-83	500	FFY 1982-83 505 (.75 x 500 + .25 x 521)
SFY 1983-84	521	FFY 1983-84 527 (505 x 1.043)
SFY 1984-85	543	FFY 1984-85 550 (527 x 1.043)

No Home Health Care was included in H in the approved waiver nor is it included in the estimate of H in the requested authorization. Home Health Care is excluded as it is unlikely that any client who is in need of both skilled nursing care and Medicaid clinic option services could meet the cost-effectiveness requirements of this long term care alternative program. The State assures, however, that no client would be denied admission to the home and community-based services program if that individual meets all the eligibility and cost-effectiveness requirements of this program. Any potential utilization of Home Health Care under these circumstances is, however, considered insignificant.

I The estimated annual Medicaid expenditure per eligible Medicaid user of the non-institutional services referred to in H is also derived from the approved waiver. In FFY 1982-83, estimated expenditures for this population was $817,500, giving a per client cost of $1,635 annually for the 500 clients in H. The estimate of I in the base year of the requested authorization is derived from the FFY 1983-84 approved base of $1,843 as reported in the State's FFY 1983-84 HCFA-371 report for the HCB-MH program. See Attachment 22. Cost estimates for I include an 8 percent annual increase.

F' The estimate of F'--the estimated annual number of beneficiaries referred to in F who would receive any of the acute care services otherwise provided under the State Plan--assumes that any beneficiary referred to in F could feasibly require acute care services and is, therefore, the same as F.

G' The estimated annual Medicaid expenditure per eligible Medicaid user of the acute care services referred to in F' is based on a sample of 33 nursing home clients receiving nursing home clinic option services in FFY 1983-84. The April 1985 CDSS Surveillance and Utilization Review System (S/URS) sample of FFY 1983-84 Medicaid expenditures for this population showed the following:

Total Medicaid expenditures	$620,088.30
Total Nursing Home Claims	$518,772.29
Total Clinic Option Services	$57,103.24
Total of All Other Services	$44,212.77

Based on these expenditures for the sample of 33 (an estimated four percent of the target population for this waiver in FFY 1983-84), the average per client expenditure for this population was:

Average Total Medicaid Expenditure	$18,790.55
Average SNF/ICF Expenditure	$15,720.37
Average Clinic Option Expenditure	$1,730.40
Average Expenditure All Other Medicaid	$1,339.78

G, therefore, is estimated to equal $3,070.18 ($1,730.40 plus $1,339.78 for All Other Medicaid).

The "With Waiver" equation factors were derived as follows:

A The estimated annual number of beneficiaries who would receive the level of care provided in an SNF or ICF with the waiver is equal to F minus C. The base for the first year of the requested waiver is the estimated FFY 1984-85 year-end population--adjusted from the estimated 546 in the FFY 1983-84 HCFA-371 to 635 based on more current information--plus 4.3% which is the historical growth pattern in SNF/ICF populations. The adjustment from the estimate of 546 included in the Second Annual HCFA-371 Report for this program to 635 results simply from a more recent estimate of FFY 1984-85 HCB-MH utilization based on later data.

B The estimated Medicaid payment per eligible Medicaid user of such institutional care is the same as G plus, under the interim equation, the cost of nursing home clinic option services. Under the revised equation, B is restricted to expenditures for ICF or SNF care. B, therefore, equals G and is, of course, derived in the same manner as G.

C The estimated number of beneficiaries who would receive home and community-based services under the waiver includes the estimated FFY 1984-85 year-end base for the HCB-MH program plus a 4.3% growth factor which is the same growth factor as is used for the ICF/SNF population.

In the revised formula, C is restricted to beneficiaries who would receive home and community-based services under the waiver and excludes "other non-institutional alternatives included under the State Plan" which was an element of C in the interim equation. This population, an estimated 550 clients in FFY 1984-85, is, therefore, eliminated from C in the requested authorization.

D The estimated annual Medicaid expenditure for home and community-based services per eligible Medicaid user is shown on TABLE II. Because of the removal of clinic option services from the waiver program, comparison with current HCB-MH rates

is difficult; however, the total cost of home and community-based services plus the added cost of clinic option services for waiver clients in the Intensive Treatment, settings in the first year of the requested authorization, for example, is estimated at $62.10 per day--almost 12.5% less than the FFY 1984-85 estimated average reimbursement rate of $69.30 per day for Intensive HCB-MH services.

C' The estimated annual number of beneficiaries referred to in C who would receive any of the acute care services otherwise provided under the State Plan assumes that all beneficiaries referred to in C could require one or more of the acute care services provided under the State Plan and is, therefore, equal to C.

D' The estimated annual Medicaid expenditure per eligible Medicaid user of acute care services otherwise provided under the State Plan is calculated using the total Medicaid costs as reflected on Schedule B of the State's Second Annual HCFA-372 Report for FFY 1983-84 for all HCB-MH clients who were in a placement other than a nursing home immediately prior to entry into the waiver. See Attachment 23: State of Colorado, Second Annual HCFA-372 Report, HCB-MH Program. This estimate was derived as follows:

Total Expenditures, less lines 3, 4 and 17	$306,702.13
Total Clients	119
Total Expenditure Per Client	$2,577.33

The acute care costs from the FFY 1983-84 HCFA-372 Schedule B were adjusted forward using the same 8 percent inflation factor as is used for all other cost projections in the cost-effectiveness equation.

Also included in D' is the cost of the additional clinic option services which the client is expected to require in the community setting. The cost of these services is estimated at $3,589.00 for FFY 1985-86. The total cost of D' is, therefore, the acute care cost as estimated from the HCFA-372--which does not include the cost of clinic option services which were being provided at that time as home and community-based services--plus the cost of the additional, or replacement, clinic option services which will be provided to the waiver client as acute care services under the requested authorization.

FFY 1985-86	Annual Cost Per Client
Acute Care Services, excluding clinic option services	$2,783
Additional Clinic Option Services to be provided in alternative setting.	$3,589
TOTAL ANNUAL COST PER CLIENT	$6,372

C. Estimates of Expenditures for Home and Community-Based Services

Utilization rates and costs for home and community-based services for the mentally ill to be provided under the Secretarial waiver for the three-year period between October 1, 1985 and October 1, 1988 are presented in TABLE II and are summarized below:

	FFY 1985-86	FFY 1986-87	FFY 1987-88
Unduplicated Clients	397.6	414.7	432.5
Total Cost	$1,225,734	$1,415,414	$1,595,973
Cost Per Client	$ 3,158	$ 3,413	$ 3,690

TABLE II shows the estimated costs for the home and community-based services program by waiver service with the Intensive and Intermittent Community Treatment Facility costs, for which the State is proposing a "bundled" per diem rate, broken out by daily, annual and total costs for each component of the "bundled" rate.

Both the Intensive and the Intermittent Community Treatment programs assume a 95 percent occupancy rate, with a maximum of 50 active certified beds in the Intensive program and 40 active certified beds in the Intermittent program in the first year of the new authorization. The average length of stay for the clients to be served in these programs is 270 days. Clients are expected to transition from the Intensive and Intermittent Treatment programs to independent living. Waiver services for the independent living population will consist primarily of case management, with approximately one-fourth of the total unduplicated population receiving personal care or homemaker services.

In addition to the home and community-based services, clinic option services will be provided to all waiver clients. TABLE III shows the amount of Medicaid clinic option services each waiver client is expected to receive in addition to the home and community-based services.

Based on the State's first full year of experience with the HCB-MH program, it is estimated that approximately 93 per cent of the HCB-MH population will be clients who are diverted from long term

STATE OF COLORADO
HOME AND COMMUNITY-BASED SERVICES--MENTAL HEALTH

TABLE II
WAIVER REQUEST — C A D CALCULATIONS
CFR 441.303 (f)
FFY 1985-86 -- FFY 1987-88

WAIVER SERVICE	FFY 1985-86	FFY 1986-87	FFY 1987-88
1 INTENSIVE RESIDENTIAL*			
UNDUPLICATED CLIENT COUNT	64.2	66.1616	69.8299815
AVERAGE LENGTH OF STAY/DAYS	270	270	270
AVERAGE COST PER CLIENT			
DAILY	72	72.4	72
PERSONAL CARE	72	72	72.15
NON-MEDICAL TRANSPORTATION	1	1.12	1.17
CASE MANAGEMENT	4	4.22	4.37
ANNUALLY	8090	8743	9448.918
PERSONAL CARE	6750	7293	7877.4
NON-MEDICAL TRANSPORTATION	270	291.6	314.9
CASE MANAGEMENT	1080	1166.4	1259.718
TOTAL COST/BUNDLED	25702D	2887T1.2888	3299D4.1400D191
PERSONAL CARE	4777ED	488142.774	5472E7.5867449E
NON-MEDICAL TRANSPORTATION	17274	19626.71076	22162.421251222
CASE MANAGEMENT	9776	78112.84784	87779.1674E817
2 INTERMITTENT COMMUNITY RESIDENTIAL*			
UNDUPLICATED CLIENT COUNT	51.37	57.57121	58.3823012
AVERAGE LENGTH OF STAY/DAYS	270	270	270
AVERAGE COST PER CLIENT			
DAILY	22	22.76	25.3252
PERSONAL CARE	17	18.76	19.2333
NON-MEDICAL TRANSPORTATION	1	1.13	1.1264
CASE MANAGEMENT	4	4.22	4.67
ANNUALLY	7290	7877.2	8505.472
PERSONAL CARE	5940	6415.2	6929.604
NON-MEDICAL TRANSPORTATION	270	291.6	314.928
CASE MANAGEMENT	1080	1166.4	1260.9
TOTAL COST/BUNDLED	447236.8	499955.534992	567767.06788224
PERSONAL CARE	374487.3	421877.474212	479207.7219916
NON-MEDICAL TRANSPORTATION	17369.9	19627.619176	17773.058424128
CASE MANAGEMENT	55479.6	62474.440624	70462.6234668A7
3 CASE MANAGEMENT (INDEPENDENT LIVING ONLY)			
UNDUPLICATED CLIENT COUNT**	397.57	414.66551	432.496:2497
AVERAGE NUMBER IF UNITS PER CLIENT	100	100	100
AVERAGE COST PER CLIENT			
PER UNIT	4	4.22	4.67
ANNUALLY	720	777.6	840.6
TOTAL COST	287342.6	322148.1288744	334274.7a245744

4	RESPITE CARE			
	UNDUPLICATED CLIENT COUNT	40	41.7	47.5
	AVERAGE LENGTH OF STAY/DAYS	30	30	30
	AVERAGE COST PER CLIENT			
	DAILY	70	72.8	74.992
	ANNUALLY	2100	2148	2209.34
	TOTAL COST	84000	87931.2	104420.14
5	PERSONAL CARE***			
	UNDUPLICATED CLIENT COUNT	99.7302	107.2887778	118.1134017726
	AVERAGE COST PER CLIENT	447.34	487.344	536.1784
	TOTAL COST	44624.2632	52321.13707576	63340.9878703218
6	HOMEMAKER SERVICES****	99.7302	107.2887778	118.1134017726
	UNDUPLICATED CLIENT COUNT	447.34	487.344	536.1784
	AVERAGE COST PER CLIENT			
	TOTAL COST			
7	TOTAL UNDUPLICATED CLIENT COUNT*****	397.67	414.66551	432.479612697
	TOTAL COST OF SERVICES	1068734.3872	1141414.8497124	1218977.8685474
8	ANNUAL AVERAGE COST PER CLIENT	2688.8253442197	2754.0888102343	2819.1487420454
			1.0240491448187	1.0236784779141

*BUNDLED RATE WHICH INCLUDES PERSONAL CARE, NON-MEDICAL TRANSPORTATION, AND CASE MANAGEMENT

**INCLUDES 119.6 CLIENTS PER 45 UNITS/UNIT X INTER
X 282 CLIENTS PER 180 UNITS/INDEPENDENT LIVING

***RATE=$4.25 PER 1/2 HOUR/2 UNITS PER HOUR/10% INF
52 WEEKS X 25% OF UNDUPLICATED CLIENT COUNT

****NON-ADD. ALTERNATIVE TO PERSONAL CARE
ESTIMATE WOULD NOT EXCEED PC ESTIMATE

*****REPRESENTS FULL UNDUPLICATED COUNT

NON-WAIVER ACUTE CARE SERVICES
AVERAGE COST PER WAIVER CLIENT

D'	ACUTE CARE SERVICES, EXCLUDING CLINIC OPTION	2783	3006	3246
	ADDITIONAL CLINIC OPTION IN HOME COMMUNITY-BASED SETTING	3539	3787	4133
	TOTAL AVERAGE COST PER CLIENT	6272	6832	7432
C'	UNDUPLICATED CLIENT COUNT	397.67	414.66551	432.479612697
	TOTAL C' X D'	2533316.04	2833723.03782	3214111.2151473

STATE OF COLORADO

ACUTE AND INTERMEDIATE SERVICES--MENTAL HEALTH

TABLE III

ESTIMATED DAILY COST OF ALTERNATIVE

FOR WAIVER CLIENTS

WAIVER REQUEST

FFY 1985-86 -- FFY 1987-88

	FFY 1985-86	FFY 1986-87	FFY 1987-88
WAIVER SERVICE			
DAILY OPTION COSTS PER CLIENT			
INTENSIVE			
CLIENTS	64.0	86.7616	87.1778[illegible]
RATE	28.11	24.8718	27.2224[illegible]
LENGTH OF STAY	271	271	271
TOTAL COSTS	524761.24	620118.1172[illegible]	7141[illegible].[illegible]7287
INTERMITTENT			
CLIENTS	81.27	83.87[illegible]	88.[illegible]810
RATE	17.69	18.[illegible]	21.[illegible]618
LENGTH OF STAY	273	273	273
TOTAL COSTS	248788.871	276781.[illegible]89784	3[illegible].[illegible]276
INDEPENDENT LIVING			
CLIENTS*	297.87	414.[illegible]	475.49[illegible]87
RATE	11.2	12.[illegible]	13.[illegible]33
UNITS	180	180	180
TOTAL COSTS*	626759.28	70[illegible].7223632	795274.[illegible]4824
TOTAL CLIENTS OPTION COSTS	1426779.181	1607406.3948524	18[illegible].3894178
UNDUPLICATED CLIENT COUNT	297.87	414.[illegible]	475.49[illegible]1872
AVERAGE COST PER CLIENT	3819.[illegible]9[illegible]	3[illegible].[illegible]79287	4[illegible].[illegible]47287
		1.16	1.08
ACUTE CARE COSTS	2782	3106	3546
TOTAL ACUTE CARE COSTS	6[illegible].[illegible]9[illegible]	6[illegible].[illegible]79287	7[illegible].[illegible]47287

*INCLUDES 180 CLIENTS FOR 180 UNITS &
[illegible] CLIENTS FOR 45 UNITS

care in a nursing care facility. This is a conservative estimate of deinstitutionalized clients and is derived from the distribution of clients between the A and B Schedules of the State's second annual HCFA-372 report for FFY 1983-84. See Attachment 23: Second Annual HCFA-372 HCB-MH Report.

Application of the 93% to the total estimated waiver costs for each year of the requested program yields the following:

	FFY 1985-86	FFY 1986-87	FFY 1987-88
Expenditures			
Diverted	$1,167,833	$1,316,335	$1,484,254
Deinstitutionalized	87,901	99,078	111,718
Total	$1,255,734	$1,415,413	$1,595,973
Unduplicated Clients			
Diverted	370	386	402
Deinstitutionalized	28	29	31
Total	398	386	433

D. Cost-effectiveness Equation

Using the estimates of utilization and costs as reflected on TABLES I and II, the values for each of the elements of the revised formula for each year of the extended waiver will be those shown on TABLE IV.

Using the revised formula as shown below and inserting the values from TABLE IV, the equations for each year of the requested authorization would be as follows:

REVISED FORMULA $$\frac{(A \times B) + (A' \times B') + (C \times D) + (C' \times D') + (H \times I)}{F + H}$$

$$\frac{(F \times G) + (H \times I) + (F' \times G')}{F + H}$$

STATE OF COLORADO
HCB-PM
TITLE XIX
TABLE IV
WAIVER RENEWAL REQUEST
CALCULATION OF VALUES FOR RENEWED
DFR 441.302 (d)
COST EFFECTIVENESS FORMULA
FFY 1986-88 -- FFY 1987-89
FOR EXTENDED WAIVER
1/23/87

WAIVER FACTOR	DEFINITION OF FORMULA FACTOR	FFY 1984-85 ADJUSTED FORMULA	ADJUSTMENT FACTORS	ESTIMATE FFY 1985-86	ADJUSTMENT FACTORS	ESTIMATE FFY 1986-87	ADJUSTMENT FACTORS	ESTIMATE FFY 1987-88
A	The estimated annual number of beneficiaries who would receive the level of care provided in an SNF or ICF with the waiver.	675		683.4	1.047	691.2	1.047	721
B	The estimated annual Medicaid expenditure for SNF or ICF care per eligible Medicaid user with the waiver.	$745	1.09	7831	1.09	8101	1.09	8749
C	The estimated annual number of beneficiaries who would receive home and community-based services under the waiver.	385		397.6	1.047	414.7	1.047	433.8
D	The estimated annual Medicaid expenditure for home and community-based services per eligible Medicaid user.	$420		7159		7412		7640
E	The estimated annual number of beneficiaries who would likely receive the level of care provided in an SNF or ICF in the absence of the waiver.	1017	1.047	1061	1.047	1105	1.047	1154
F	The estimated annual Medicaid expenditures per eligible Medicaid user of such institutional care in the absence of the waiver.	$745	1.09	7831	1.09	8101	1.09	8749
H	The estimated annual number of beneficiaries who would receive any of the noninstitutional, long-term care services otherwise provided under the State plan as an alternative to institutional care.	550	1.047	574	1.047	599	1.09	647

I	The estimated annual Medicaid expenditure per eligible Medicaid user of the non-institutional services referred to in H	1980	1.03	2149	1.06	2278	1.06	2357
A'	The estimated annual number of beneficiaries referred to in A who would receive any of the acute care services otherwise provided under the State plan.			662.4	1.042	691.2	1.042	721
B'	The estimated annual Medicaid expenditure per eligible Medicaid user of the acute care services referred to in A'.			3591	1.13	3967	1.09	4177
C'	The estimated annual number of beneficiaries referred to in C who would receive any of the acute care services otherwise provided under the State plan.			377.6	1.042	414.7	1.042	432.8
D'	The estimated annual Medicaid expenditure per eligible Medicaid user of acute care services otherwise provided under the State plan.			4272	1.09	4655	1.09	5077
E'	The estimated annual number of beneficiaries referred to in E who would receive any of the acute care services otherwise provided under the State plan.			1061	1.042	1105	1.042	1151
G'	The estimated annual Medicaid expenditures per eligible Medicaid user of the acute care services referred to in E'.			3591	1.09	3967	1.09	4177

FFY 1985-86 WITH WAIVER

$$\frac{(663.4 \times 7501) + (663.4 \times 3581) + (397.6 \times 3159) + (397.6 \times 6372) + (574 \times 2149)}{1061 + 574}$$

$$\frac{4976163.4 + 2375635 + 1256018.4 + 2533507 + 1233526}{1635}$$

$$\frac{12374850}{1635} = \$7{,}569 \text{ Annual Cost Per Client}$$

FFY 1985-86 WITHOUT WAIVER

$$\frac{(1061 \times 7501) + (574 \times 2149) + (1061 \times 3581)}{1061 + 574}$$

$$\frac{7958561 + 1233526 + 3799441}{1635}$$

$$\frac{12991528}{1635} = \$7{,}946 \text{ Annual Cost per Client}$$

FFY 1986-87 WITH WAIVER

$$\frac{(691.3 \times 8101) + (691.3 \times 3867) + (414.7 \times 3413) + (414.7 \times 6881) + (599 \times 2321)}{1106 + 599}$$

$$\frac{5600221.3 + 2673602.8 + 1415371.1 + 2852965.4 + 1390279}{1705}$$

$$\frac{13933440}{1705} = \$8,172 \text{ Annual Cost Per Client}$$

FFY 1986-87 WITHOUT WAIVER

$$\frac{(1106 \times 8101) + (599 \times 2321) + (1106 \times 3867)}{1106 + 599}$$

$$\frac{8959706 + 1390279 + 4276902}{1705}$$

$$\frac{14626887}{1705} = \$8,579 \text{ Annual Cost per Client}$$

FY 1987-88 WITH WAIVER

$$\frac{(721 \times 8749) + (721 \times 4177) + (432.5 \times 3690) + (432.5 \times 7433) + (647 \times 2507)}{1154 + 647}$$

$$\frac{6308029 + 3011617 + 1595925 + 3214772.5 + 1622029}{1801}$$

$$\frac{15752373}{1801} = \$8,746 \text{ Annual Cost Per Client}$$

FFY 1987-88 WITHOUT WAIVER

$$\frac{(1154 \times 8749) + (647 \times 2507) + (1154 \times 4177)}{1154 + 647}$$

$$\frac{10096346 + 1622029 + 4820258}{1801}$$

$$\frac{16538633}{1801} = \$9,183 \text{ Annual Cost Per Client}$$

The "with" and "without waiver" cost per client for each year of the requested authorization is:

	WITH WAIVER	WITHOUT WAIVER
FFY 1985-86	$7,569	$7,946
FFY 1986-87	$8,172	$8,579
FFY 1987-88	$8,746	$9,183

Based on the unduplicated client count, the estimated savings for each of the three years will be:

FFY 1985-86	$130,124
FFY 1986-87	$140,316
FFY 1987-88	$150,616

As indicated in Section II, the goal of this request is to provide more appropriate, cost-effective services to the State's long term care mentally ill population. The 1982 Colorado State Health Plan identified chronically mentally ill residents in nursing homes as a "very serious problem to the long-term care system." The Plan indicated that psychiatric residents in nursing homes not only present problems for the geriatric residents because the mentally ill often do not mix well with other residents but also because the quality of care for mentally ill clients in nursing homes was, at that time, less than optimal. Although the State has since acted to extend Medicaid clinic option services to mentally ill clients in nursing homes, problems presented by the adverse impact of the mentally ill clients on the geriatric residents still exists.

The home and community based services program has offered the State and Federal governments the opportunity to provide more appropriate and effective treatment in the least restrictive settings to the ICF/SNF mentally ill population. Continuation of the home and community-based services program first authorized in 1983 is considered essential to both the care and treatment of this population and the containment of long term care costs.

SECTION IX: SUMMARY OF ASSURANCES

The following assurances are provided in direct response to the assurances and supporting documentation required by Sections 441.302 and 441.303 of the final regulations, as published in Vol. 50, No. 49, Federal Register, March 13, 1985.

441.302 (a) Health and Welfare

(1) Assurance: The State of Colorado assures HCFA that necessary safeguards have been taken to protect the health and welfare of the recipients of the services. These safeguards include adequate standards for all types of providers that provide services under the waiver.

Documentation: See Attachment 16 : Colorado Department of Health, Residential Care Facilities for the Mentally Ill, Chapter XIII (2); Attachment 19: Colorado Department of Social Services, Staff Manual Volume 7, Adult Foster Care Regulations; Attachment 24: Colorado Department of Health, Chapter III General Building and Fire Safety Standards; Attachments 17 and 18: Colorado Department of Health, Nursing Care Facility, Chapter V and Intermediate Health Care Facility, Chapter VI; Attachment 2, Colorado Department of Social Services, Medical Assistance Staff Manual Volume 8, Sections 8.057, 8.400-8.406, 8.481, 8.484, 8.487 and 8.509-8.511; Attachment 10, Colorado Department of Institutions, Division of Mental Health, Standards/Rules and Regulations for Mental Health, 2 CCR 502-2.

(2) Assurance: The State of Colorado assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver.

Documentation: Attachment 2: Colorado Department of Social Services, Medical Assistance Staff Manual Volume 8, Sections 8.487 and 8.510; Attachment 10: Colorado Department of Institutions, Division of Mental Health, Standards/Rules and Regulations for Mental Health.

(3) Assurance: The State of Colorado assures HCFA that all facilities covered by Section 1616 (e) of the Social Security Act, in which home and community-based services will be provided will be in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

Documentation: See Attachment 16: Colorado Department of Health, Residential Care Facilities for the Mentally

III, Chapter XIII (2); Attachment 19: Colorado Department of Social Services, Staff Manual Volume 7, Adult Foster Care Regulations; Attachment 24: Colorado Department of Health, Chapter III General Building and Fire Safety Standards; Attachments 17 and 18: Colorado Department of Health, Nursing Care Facility, Chapter V and Intermediate Health Care Facility, Chapter VI.

441.302 (b) Financial Accountability

Assurance: The State of Colorado assures HCFA that it will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of the HCB-MH waiver program and maintain and make available to the Department of Health and Human Services, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

441.302 (c) Evaluation of Need

Assurance: The State assures HCFA that it will provide for an evaluation and periodic reevaluations of the need for the level of care provided in an SNF or ICF, as defined by 42 CFR 440.40, when there is a reasonable indication that the individuals might need such services in the near future but for the availability of home and community-based services.

Documentation: See Attachment 2: Colorado State Department of Social Services, Medical Assistance Staff Manual Volume 8, Long Term Care - General, Sections 8.400 through 8.481 and Home and Community Based Services--Mental Health (HCB-MH), 8.509.8.

Sections 8.400 through 8.481 describe the State's admission procedures for long term care and for home and community-based services and establish the level of care screening guidelines and the requirement for continued stay review which ensures reevaluation of need at regular intervals. Section 8.509.8 describes the roles and responsibilities of the PSRO and the HCB-MH providers, the community mental health centers and clinics, in the evaluation and reevaluation processes.

The level of care screening guidelines are applied by the State's Professional Review Organization, the Colorado Foundation for Medical Care. See Attachments 7 and 8: Procedures for Level of Care Assessment and Procedures for Medicaid Continued Stay Review, respectively. These attachments include descriptions of the procedures which ensure the maintenance of written documentation on all evaluations and reevaluations and include a copy of the LTC 101, the State's long term care evaluation instrument.

441.302 (d) Alternatives

Assurance: The State assures that, when a recipient is determined to be likely to require the level of care provided in an SNF or ICF, the recipient or his or her legal representative will be: (1) informed of any feasible alternatives available under the waiver, and (2) given the choice of either institutional or home and community-based services.

Documentation: See Attachment 2: Colorado Department of Social Services Medical Assistance Staff Manual Volume 8, Long Term Care - General, 8.484.20; Recipient Appeal and Hearings, Section 8.057; and Home and Community-Based Services--Mental Health, Sections 8.509.9 and 8.510.5.

This section of the Medical Assistance rules applicable to Home and Community Based Services--Mental Health describes the Intake Process for this program and in subsections d. 6., 7., and 8. establishes the requirement that the client be offered institutional care in a nursing care facility or alternative service in the home or community-based services program, if such services are determined to be appropriate. Documentation of the client's choice is retained in the clients's case records which is maintained by the community mental health center provider. Also See Attachment 12: Client Choice Form.

441.302 (2) Expenditures

Assurance: The State of Colorado assures that the average per capita fiscal year expenditures under the waiver will not exceed the average per capita expenditures for the level of care provided in an SNF or ICF under the State plan that would have been made in that fiscal year had the waiver not been granted.

Assurance: The State of Colorado assures that the State's actual total expenditures for home and community-based services under the waiver and the State's claim for FFP in expenditures for the services will not exceed the State's approved estimates for these services, expressed as the product of (C x D) in the cost effectiveness calculations presented in this request.

Assurance: The State of Colorado assures that the State's actual total expenditures for home and community based services for the mentally ill and other Medicaid services provided to HCB-MH clients under the waiver will not, in any year of the waiver period, exceed the amount that would be incurred by Medicaid for these individuals in an SNF or ICF in the absence of the waiver.

Documentation: See SECTION VIII for calculations of cost effectiveness and supporting documentation required by 441.303 (f).

441.303 (e) Post Eligibility Treatment of Income

Documentation: See Attachment 2: Colorado Department of Social Services Medical Assistance Staff Manual Volume 8, Home and Community Based Services, Section 8.484.10.

This section describes the application of post eligibility treatment of income and resources requirements for the State's home and community-based services populations, including the methodology used for calculation of the patient payments, the agency or staff responsible for calculation, assessment and collection of the payment, and processes and procedures relating to record retention, failure to pay and application of payments.

441.302 (f) Reporting

The State of Colorado assures that, annually, the State will provide HCFA with information on the waiver's impact and that such information will be consistent with a data collection plan designed by HCFA and will address the waiver impact on:

(1) the type, amount and cost of services provided under the State Plan; and

(2) the health and welfare of recipients.

441.303 (g) Independent Assessment

The State assures HCFA that it will provide for an independent assessment of the quality of care provided by the HCB-MH program, client access to care and the cost effectiveness of the services provided. The State further assures that the results of the assessment, which will cover at least the first 24 months of the waiver, will be submitted to HCFA at least 90 days prior to the third anniversary of the approved waiver period.

LIST OF ATTACHMENTS

Attachment 1: Colorado Client Assessment Record, User's Guide, June 1980.

Attachment 2: Colorado Department of Social Services, Medical Assistance Staff Manual Volume 8, Sections 8.400.15 and 8.509.4.

Attachment 3: House Bill No. 1213.

Attachment 4: Articles 1 and 10 of Title 27, Colorado Revised Statutes.

Attachment 5: Executive Directors for Colorado's community mental health centers and clinics.

Attachment 6: A map showing the catchment area of each Colorado community mental health center and clinic.

Attachment 7: Colorado Foundation for Medical Care, Long Term Admission Certification Guidelines.

Attachment 8: Colorado Foundation for Medical Care, Procedures for Medicaid Continued Stay Review.

Attachment 9: Colorado Foundation for Medical Care, LTC-101, Admission Certification Guidelines.

Attachment 10: Department of Institutions, Division of Mental Health, Standards/Rules and Regulations for Mental Health, 2 CCR 502-2.

Attachment 11: Colorado Department of Institutions, Division of Mental Health, Assessment of Long Term Cost-Effectiveness.

Attachment 12: Client Choice Form.

Attachment 13: Medical Necessity Form.

Attachment 14: Department of Institutions, Division of Mental Health, Clinical Quality Assurance Guidelines for Clinical Care, Reviews and Review Examples, March, 1980.

Attachment 15: Department of Institutions, Division of Mental Health, Care and Treatment of the Mentally Ill, Rules and Regulations, July 30, 1984.

Attachment 16: Colorado Department of Health, Residential Care Facilities for the Mentally Ill, Section VII.

Attachment 17: Colorado Department of Health, Nursing Care Facility, Chapter V.

Attachment 18: Colorado Department of Health, Intermediate Health Care Facility, Chapter VI.

Attachment 19: Colorado Department of Social Services, Medical Assistance Staff Manual Volume 7, Adult Foster Care Regulations.

Attachment 20: Colorado Department of Social Services, Division of Aging and Adult Services (AASD), Analysis of HCFA-2082 Reports, FFY 1981-84.

Attachment 21: State of Colorado, Excerpt from HCB-DD FFY 1983-84 HCFA-371 Report, pages 3.3 through 3.6.

Attachment 22: State's FFY 1983-84 HCFA-371 report for the HCB-MH program.

Attachment 23: State of Colorado, Second Annual HCFA-372 Report, HCB-MH Program.

Attachment 24: Colorado Department of Health, General Building and Fire Safety Standards, Chapter III.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

OCT 25 1985

— Exhibit 2

DEPT. OF SOCIAL SERVICES
OFFICE OF EXECUTIVE DIRECTOR
RECEIVED
OCT 28 1985

George S. Goldstein, Ph.D.
Executive Director
State of Colorado
Department of Social Services
1575 Sherman Street
Denver, Colorado 80203

Dear Dr. Goldstein:

This is in reference to your request for a home and community-based services waiver as authorized by section 1915(c) of the Social Security Act for mentally ill Medicaid recipients who would otherwise require skilled nursing facility services or intermediate care facility services.

We are sympathetic to and wish to support your desire to find more cost-effective methods of providing and reimbursing for medical assistance. However, we believe that the waiver request does not fully comply with all of the statutory and regulatory requirements necessary for approval. Accordingly, we cannot approve this waiver request under section 1915(c) of the Social Security Act. For your information, we have enclosed a report on those aspects of the waiver request which present the major barriers to approval.

I regret that my response could not be more favorable.

Sincerely yours,

C. McClain Haddow

C. McClain Haddow
Acting Administrator

Enclosure

Report on Colorado's Waiver

Colorado has failed to comply with the following statutory and regulatory assurances during its current waiver.

1. Section 1905(a)(18)(B) of the Social Security Act prohibits Medicaid payments ". . . with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases." Section 1905(a)(16) provides an exception which allows payment for inpatient psychiatric hospital services for individuals under age 21. Because Medicaid payment is precluded for individuals in the 21-64 age group in institutions for mental diseases (IMDs) Medicaid payment is also precluded under the home and community-based services waiver program for individuals who would otherwise have been institutionalized in an IMD.

   Colorado, in its original waiver, assured the Health Care Financing Administration (HCFA) that no individuals would receive services under the waiver who were under 65 and who would otherwise receive services in a hospital, SNF or ICF that has been certified as an IMD. (October 15, 1982 response to HCFA's request for additional information.) However, the regional office assessments of the waiver program over the last 2 years found that the majority of waiver recipients are individuals in this age group who were previously institutionalized in an IMD. The State attempted to circumvent the Federal prohibition by holding individuals released from inpatient psychiatric care for 15 days before placing them in the waiver. However, it is HCFA's position that the State's "holding" procedure has no impact on the character of an individual recipient and that these are individuals who, absent the waiver, would be in an IMD and are, therefore, not eligible for Medicaid benefits.

2. Section 1915(c)(1) authorizes the provision of home and community-based services necessary for individuals to remain in the community and avoid institutionalization. HCFA has interpreted this requirement as excluding payment for prevocational and vocational training which are not commonly furnished as a means of avoiding institutionalization.

   The most recent regional office assessment review of Colorado's waiver found that the State has been providing prevocational services under the waiver. Furthermore, although the State was notified on March 4, 1985 that such services are not reimbursable under a home and community-based services waiver, the new request continues to list such services as a waiver element. (Attachment 2, page 22.12.245.)

In addition, the State's waiver request itself contains a number of deficiencies. Among the more significant problems are:

1. Per capita expenditure estimate formula—42 CFR 441.303(f) which implements section 1915(c)(2) of the Act requires that the agency furnish HCFA with supporting documentation of how the agency estimated the per capita expenditures for both institutional and noninstitutional services. This information must include the estimated utilization rates and costs for institutional and

noninstitutional services. Additionally, 42 CFR 441.302(e) requires that the expenditures be reasonably estimated. With respect to this requirement we find that:

a) For each service in each category, Colorado did not: identify the number of recipients who will receive the service; define a unit of service; provide the average number of units of service a recipient will receive as well as the cost per unit of service; and adjust by a phase-in plan or the average length of stay.

b) The State did not provide separate per capita expenditure estimate formula data for the SNF and ICF levels of care in addition to the combined formula.

c) The State did not base its formula projections on the total number of individuals who would receive SNF and ICF care with and without the waiver but rather on the proportion of those individuals who the State estimated were mentally ill.

d) In its calculation of D, the State presents separate cost-estimates for each of three service intensity levels it plans to target under the waiver: intensive residential, intermittent community residential, and independent living. The average per capita cost of providing waiver services to the intensive residential group exceeds the average per capita costs of institutionalization. Further, the average per capita cost of providing waiver services for the intermittent community residential group as reported by the State is 97 percent of the cost of institutionalization. Additionally, although the application states that recipients move between levels of care, the estimated utilization and cost of waiver services does not appear to account for this movement. Both intensive and intermittent levels of care reflect 270 days as the average length of stay and unduplicated recipients in each group. Absent a clear indication of the cost impact of the movement between groups, we are unable to determine that the State's estimates are reasonable.

e) Colorado did not provide documentation based on unit costs and utilization per client per service to support its estimates of the other acute care services which would be provided to institutionalized and waiver recipients (B', D' and G' of the cost-effectiveness formula.)

f) Colorado provides home health services under its State plan, yet did not include these services and costs in H and I of the per capita expenditure estimate formula as required. Furthermore, although it appears from the waiver narrative that some waiver recipients would be receiving more than the usual amount of home health services, these costs were similarly not included in D' of the formula.

g) Colorado did not provide the number of persons on nursing home waiting lists for each type of institution and the length of time individuals must wait for admission.

h) The State did not provide information regarding where individuals come from who are diverted or deinstitutionalized from SNF or ICF care. Colorado provided the number of total diversions and deinstitutionalizations but not the numbers by level of care.

2. Colorado has not specifically described who provides each of the various waiver services nor have they submitted standards/minimum qualifications for each type of provider. (42 CFR 441.302(a)(1)).

3. The State has not indicated for how long documentation of evaluations and reevaluations will be maintained. (42 CFR 441.303(c)).

4. States may provide under the waiver home and community-based services other than those specifically enumerated in the statute and regulations. In order to be granted approval to provide such services, the State must: clearly define such services; demonstrate the services are cost-effective by comparing them to the cost of institutional care; and assure us that the services are necessary to avoid institutionalization. The cost-effectiveness demonstration must be in addition to the average per capita expenditure estimates. Colorado did not demonstrate the cost-effectiveness of nonmedical transporation services nor did it specifically assure us that nonmedical transportation services are necessary to avoid institutionalization. (42 CFR 440.180(h)).

5. Colorado's waiver request does not specifically exclude the costs of room and board from anything but the "bundled rate" case management, personal care, and nonmedical transportation services. (42 CFR 441.310(a)(3)).

6. Colorado did not provide a description of the records and information that will be maintained by the agency and by providers of waiver services to support financial accountability, inform HCFA how it will meet the requirement and explain how it will assure that there is an audit trail for all State and Federal funds (42 CFR 441.303(b)).

7. In its explanation of how it will apply the post-eligibility treatment of income rules in 42 CFR 435.726, Colorado indicates that its maintenance needs allowance for an individual will be based on the standard for its State Supplementary Payment program. However, eligibility for Colorado State Supplementary Program (SSP) payment is limited to aged individuals. Under 435.726(c)(1)(ii) a State may establish a maintenance needs amount which does not exceed "The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State Supplement recipients under §435.230." Because Colorado does not include blind and disabled individuals in its SSP program it does not have an SSP income eligibility standard for blind and disabled individuals. Additionally, because 435.726(C)(2)(ii) indicates that the maintenance needs amount may be the amount of the highest income standard "in the appropriate category," Colorado may not employ its aged OAP standards for blind and disabled individuals. As such, the only remaining option is under 435.726(C)(1)(i) which requires that the maintenance needs amount not exceed the SSI payment amount for an individual in his own home, i.e., $325. The State therefore did not reflect the appropriate maintenance needs amounts which must be protected under 435.726.

8. In Attachment 2, Colorado Department of Social Services Medical Assistance Manual Volume 8, section 8.484.10 the State sets out supporting documentation relating to post-eligibility treatment of income and resources.

a) In section 8.484.11, in its discussion of post-eligibility treatment of income for the group eligible under the special income level, the State indicates "Failure to pay the amount assessed for this purpose shall cause the HCB services to be discontinued unless good cause is established in accordance with these rules." Regulations at 42 CFR 435.726 require that the State's payment for waiver services be reduced by the amount that remains after deducting certain allocations from the individual's income. 435.726 does not legally bind the recipient to pay the cost-sharing amount in order that the individual's Medicaid eligibility be continued. As such, Colorado's requirement that individuals who refuse to pay their share of cost be terminated from Medicaid does not conform with the requirements of 42 CFR 435.726.

b) Section 8.484.13d. provides for a deduction from income for personal home care service payments in the post-eligibility calculation if such services are actually being purchased. Regulations at 42 CFR 435.726 specify that a State must reduce its Medicaid payment by the amount of the individual's income which remains after deducting: 1) a maintenance needs amount for the individual (435.726(c)(1)); 2) a maintenance needs amount for a spouse (435.726(c)(2)); 3) a maintenance needs amount for a family (435.726(c)(3)); and 4) amounts for incurred medical and remedial care not subject to payment by a third party (435.726(c)(4)). There are no provisions under 435.726 which would permit the State to deduct any additional amounts from an individual's income. As such, the Colorado proposal to deduct additional amounts for personal home care services violates the requirements of 42 CFR 435.726.

We note, however, if these personal home care services fall within the State definition of medical or remedial care Colorado may deduct an amount for these services under 435.726(c)(4)(ii).

Finally, Colorado does not describe the difference between personal home care services and the personal care services provided as a waiver service. Since necessary personal care services are already furnished as a Medicaid waiver service it does not appear appropriate that the State proposes to make a separate post-eligibility deduction for these services.

c) Section 8.484.13e.1. requires the deduction of amounts for health insurance premiums, provided policies for which the premiums are allowed do not duplicate each other. Regulations at 42 CFR 435.726(c)(4)(i) which require that amounts paid for health insurance premiums be deducted, does not permit States to impose any limitations on the amount deducted. Other health insurance policies are vehicles for reducing Federal Medicaid expenditures and the regulations do not permit any limitation of the recipient's incentive to obtain other health insurance. As such, the State's procedure to limit deduction of amounts only for health insurance premiums on policies which do not duplicate coverage is in conflict with the requirements of 435.726(c)(4)(i).

d) Section 8.484.17 and 18 further discuss termination of eligibility where the recipient fails to contribute the cost-share amount. The comments provided under item 8.a. above, apply to these sections as well.

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

AUG 28 1985

— Exhibit 3

George S. Goldstein, Ph.D.
Executive Director
Department of Social Services
1575 Sherman Street
Denver, Colorado 80203

SEP 6 1985

Dear Dr. Goldstein:

This is in response to your letter requesting waivers of Medicaid statutory and regulatory provisions to provide home and community-based services as authorized by section 1915(c) of the Social Security Act to eligible mentally ill persons.

Review of the request is currently underway. When the review has been completed, you will be advised of our determination.

Sincerely,

Margaret M. Heckler

Margaret M. Heckler
Secretary

1990

An Act

Exhibit

UNPROOFED
ADVANCE
UNOFFICIAL COPY

SENATE BILL 90-192.

BY SENATORS Wham, Bird, DeNier, and Rizzuto;
also REPRESENTATIVES Taylor-Little, Gillis, Grampsas, Kerns, Neale, Pankey, Ratterree, Ulvang, Fish, Martin, Masson, and Owen.

CONCERNING THE ELIMINATION OF THE AUTHORITY TO PROVIDE HOME AND COMMUNITY-BASED SERVICES TO THE MENTALLY ILL.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. 26-4.5-201, Colorado Revised Statutes, 1989 Repl. Vol., is amended to read:

26-4.5-201. Short title. This part 2 shall be known and may be cited as the "Home and Community-based Services for ~~Mentally---Ill---Persons---and~~ Persons with Developmental Disabilities Act".

SECTION 2. The introductory portion to 26-4.5-202 (1) and 26-4.5-202 (1) (b), (1) (f), and (3), Colorado Revised Statutes, 1989 Repl. Vol., are amended to read:

26-4.5-202. Legislative declaration. (1) IT IS THE INTENT OF THE GENERAL ASSEMBLY TO PROVIDE COST EFFECTIVE SERVICES IN THE LEAST RESTRICTIVE SETTING TO INDIVIDUALS WHO ARE MENTALLY ILL. IT IS FROM THAT PHILOSOPHY THAT THE GENERAL ASSEMBLY AUTHORIZED AND THE STATE IMPLEMENTED A HOME AND COMMUNITY-BASED SERVICES PROGRAM UNDER THE AUSPICES OF A FEDERAL MEDICAID WAIVER. INASMUCH AS THE FEDERAL GOVERNMENT HAS BEEN UNWILLING TO CONTINUE COLORADO'S WAIVER, THE ENABLING STATE STATUTORY PROVISIONS FOR THAT MEDICAID FUNDED PROGRAM ARE HEREBY REMOVED. HOWEVER, THE GENERAL ASSEMBLY HAS AN ONGOING INTEREST IN EXAMINING THE NEEDS OF THOSE WHO ARE IN NEED OF LONG TERM CARE BECAUSE OF THEIR MENTAL ILLNESS AND IN THE MOST COST EFFECTIVE MENTAL HEALTH AND SUPPORTIVE SERVICES AS MAY BE NECESSARY TO ALLOW THE GREATEST DEGREE OF

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

INDEPENDENCE. IN FURTHERANCE OF THIS INTENT, THE DEPARTMENT OF INSTITUTIONS IS CHARGED TO REPORT TO THE GENERAL ASSEMBLY ON OR BEFORE JANUARY 1, 1991, ON ANY ADDITIONAL STATUTORY, BUDGET, OR ADMINISTRATIVE MODIFICATIONS THAT WILL FACILITATE THE GOAL OF HOME AND COMMUNITY-BASED CARE FOR THE MENTALLY ILL. The general assembly hereby finds and declares that it is the purpose of this article to provide services for the developmentally disabled ~~and--the--mentally--ill~~ which would foster the following goals:

(b) To recognize the unique services requirements of the ~~mentally-ill-and-the~~ developmentally disabled;

(f) To coordinate, integrate, and link these social, habilitative, remedial, residential, and health services into existing community-based service delivery systems for the developmentally disabled, ~~and--the--mentally--ill,~~ to avoid unnecessary and expensive duplication of services;

(3) Nothing in this part 2 shall be construed to disqualify persons from receiving any benefits to which they would otherwise be eligible under the "Colorado Medical Assistance Act", article 4 of this title, or under Title XIX of the federal "Social Security Act", as amended, by reason of being designated as a ~~mentally-ill-person-or-a~~ person with developmental disabilities.

SECTION 3. The introductory portion to 26-4.5-203 (2) and 26-4.5-203 (5), Colorado Revised Statutes, 1989 Repl. Vol., are amended to read:

26-4.5-203. Definitions. (2) "Eligible person" means a ~~mentally--ill--person---or---a~~ person with developmental disabilities:

(5) "Plan of care" means a coordinated plan of care for provision of services in other than a nursing home or institutional setting, developed and managed, subject to review and approval pursuant to section 26-4.5-204, by a ~~community--mental--health--center,--a--clinic-for-mentally-ill persons,-or~~ a community centered board for persons with developmental disabilities. This plan of care shall fully identify the services to be provided to eligible persons. Prior to the provision of those services, a physician may be required to review a plan of care to insure that it adequately addresses the medical needs of the eligible person.

SECTION 4. 26-4.5-204 (1), Colorado Revised Statutes, 1989 Repl. Vol., is REPEALED AND REENACTED, WITH AMENDMENTS, to read:

26-4.5-204. Duties of the department of social services

and the department of institutions. (1) The department of social services and the department of institutions shall provide a system of reimbursement for services provided pursuant to this part 2 which encourages the most cost-effective provision of services.

SECTION 5. 26-4.5-204 (4), Colorado Revised Statutes, 1989 Repl. Vol., is amended to read:

26-4.5-204. Duties of the department of social services and the department of institutions. (4) The department of institutions shall promulgate such rules and regulations as are necessary to implement the provisions of this part 2 and to fulfill the responsibilities and duties set out in ~~articles 10 and~~ ARTICLE 10.5 of title 27, C.R.S. Such rules and regulations shall be promulgated pursuant to section 24-4-103, C.R.S.

SECTION 6. 26-4.5-206, Colorado Revised Statutes, 1989 Repl. Vol., is amended to read:

26-4.5-206. Appropriations. To carry out duties and obligations pursuant to this part 2 and for the administration and provision of services to eligible persons, all medicaid funds appropriated pursuant to Title XIX of the federal "Social Security Act", as amended, for the provision of nursing home care for the developmentally disabled ~~and--the mentally-ill~~ and all other funds otherwise appropriated by the general assembly as additional sources of program funding shall be available for the placement of eligible individuals either in nursing homes or alternatives to nursing homes.

SECTION 7. Repeal. 26-4.5-203 (3) and (4) and 26-4.5-209, Colorado Revised Statutes, 1989 Repl. Vol., are repealed.

SECTION 8. Safety clause. The general assembly hereby

finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Ted L. Strickland
PRESIDENT OF
THE SENATE

Carl B. Bledsoe
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Joan M. Albi
SECRETARY OF
THE SENATE

Lee C. Bahrych
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

APPROVED _____

Roy Romer
GOVERNOR OF THE STATE OF COLORADO

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

MAY 17 1990

Exhibit 5

The Honorable Patricia Schroeder
House of Representatives
Washington, D.C. 20515

Dear Mrs. Schroeder:

I am responding to your letter to Secretary Sullivan raising a number of questions about the availability of section 1915(c) home and community-based services programs for mentally ill persons. You note that Colorado had such a waiver for mentally ill persons, but was denied renewal of the program in 1985. You also indicate advocates for the mentally ill are urging Colorado Medicaid officials to again apply for such a waiver. However, State officials indicate that the Department of Health and Human Services (HHS) will not approve waivers for the mentally ill.

I will respond to your questions in the order in which you raised them.

1. Does HHS believe that section 1915(c) of the Social Security Act (the Act) still provides a basis for States requesting and securing approval of home and community-based services programs for the mentally ill?

   Section 1915(c) is the basis for States requesting and securing approval of a home or community-based services program for the mentally ill. Under a section 1915(c) waiver, a State may include as medical assistance home or community-based services. However, such services may only be provided to persons who would otherwise require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded. Furthermore, the waiver must be budget neutral. This means, under the waiver, the estimated average per capita expenditure for such individuals must not exceed the average per capita expenditure for those individuals if the waiver had not been granted. There is no statutory prohibition to providing home and community-based services for the mentally ill.

Nonetheless, these waivers are also limited by other sections of the statute that govern payments for the mentally ill. Section 1905(a) excludes from "medical assistance" payments for "care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis or mental diseases." Section 1905(a)(16) allows payment for individuals under age 21, but only if they are receiving inpatient psychiatric hospital services. Thus, payment is not available under Medicaid for individuals over 21 and under 65 in an institution for mental diseases (IMD).

Health Care Financing Administration (HCFA) Regional Office staff conducted an on-site review of Colorado's home and community-based services waiver for the mentally ill. They found that the majority of waiver recipients served were individuals in the 21-64 age group who were previously inpatients of an IMD. Because Medicaid funds are not available for these individuals, Colorado could not make a showing of budget neutrality if it were to give these individuals home and community-based services. (A State may provide home and community-based waiver services to those between the ages of 21 and 65 who were institutionalized, but not in an IMD.) Any costs incurred in serving these individuals under the waiver would logically be more than the costs incurred in serving these individuals outside a waiver because no Medicaid costs were (or should be) incurred for these individuals outside the waiver.

If Colorado wishes to request a section 1915(c) waiver to provide home and community-based services for the mentally ill, it must show that its proposal meets the statutory requirements, including a showing of budget neutrality.

2. What standards does HHS apply to applications and what assistance will HHS give Colorado officials in developing an appropriate application?

The Department applies the same standards to waivers for the mentally ill as it does to all other requests for waivers. The applications

are reviewed to ensure they meet the requirements of the governing Federal regulations at 42 CFR 441, Subpart G. A detailed State Medicaid Manual transmittal designed to assist States in developing waivers was issued to all State Medicaid agencies in September 1988. In addition, HCFA regional and central office staff are available to assist the State in developing proposals, as they have with Colorado's other approved home and community-based services waivers.

3. Are there any other Federal programs to serve mentally ill persons in small group homes or independent living settings?

The Medicare Catastrophic Coverage Act of 1988 revised the definition of an IMD by excluding facilities of 16 beds or less. This revised definition was not affected by the repeal of many sections of that legislation. Therefore, Federal funding is available for individuals residing in such small facilities to the extent that the facilities meet the requirements for another type of Medicaid certification, such as an intermediate care facility or a skilled nursing facility. If the State has a sufficient number of these smaller facilities, it could compare the costs of providing services to those individuals in the smaller facilities to the estimated costs of services provided to those individuals under a waiver. This comparison could result in a showing of budget neutrality.

Mentally ill individuals who are Medicaid eligible and not subject to the exclusion for residents of an IMD may also receive all of the services provided by a State under its Medicaid State plan. For the categorically needy, States must provide the following services: inpatient and outpatient hospital services, rural health services, clinic services, other laboratory and x-ray services, skilled nursing facility and home health services

for individuals age 21 and older, early, periodic, screening, diagnostic and treatment services for individuals under age 21, family planning services and supplies, physician services and nurse midwife services. In addition to these mandated services, a State may elect to provide any of a combination of optional services such as clinic services, prescribed drugs, diagnostic services, preventive services, emergency hospital services, personal care services and targeted case management services. Targeted case management services, in particular, may be structured to assist mentally ill individuals to access Medicaid and other available community resources. Such a case management system for the severely mentally ill is currently in operation in Ohio. Information may be obtained by contacting Mr. Paul Offner, Deputy Director, Benefits Administration, Medicaid Administration, 31st Floor, Department of Human Services, 30 East Broad Street, Columbus, Ohio 43266-0423. His telephone number is (614) 466-3196.

4. Is it true that no State currently has an approved home and community based services program for the mentally ill under section 1915(c) of the Social Security Act? If so, why?

Due to the very limited target population which may be served, few States have attempted to design home and community-based services waiver programs for the mentally ill. The State of Vermont currently has the only operational waiver for this group. Information on the program may be obtained through the Department of Social Welfare, Vermont Agency of Human Services, 103 South Main Street, Waterbury, Vermont 05676. The Director of the Division of Medicaid is Mr. Elmo A. Sassorossi. His telephone number is (802) 241-2880.

I hope the above information is responsive to your needs.

Sincerely,

Gail R. Wilensky, Ph.D.
Administrator

EXHIBIT B

SUPREME COURT, STATE OF COLORADO
Case No. 91SC189

ORDER OF COURT

DUC VAN LE, on behalf of himself and the class of persons similarly situated, Petitioner,

v.

IRENE M. IBARRA, in her official capacity as the Executive Director of the COLORADO DEPARTMENT OF SOCIAL SERVICES; HENRY SOLANO, in his official capacity as Executive Director of the COLORADO DEPARTMENT OF INSTITUTIONS; ROBERT BAUSERMAN, ROBBIE L. BEAN, SUSANNE D. DOSH, DENNIS FISHER, MARY KYER, PEGGY STOKSTAD, JOHN P. STONE, and RICHARD F. WALKER in their official capacities as members of the COLORADO BOARD OF SOCIAL SERVICES, Respondents.

On consideration of the petition for rehearing, and reargument, and the petitions and briefs of amici curiae supporting the petition for rehearing and reargument, the Court orders, with Justice Vollack not participating, that the petitions and briefs of the amici curiae be accepted and that the petition for rehearing is Granted. Whether reargument will be granted will be determined after tne submission of supplemental briefs by the parties.

Accordingly, It Is Ordered that the opinion of April 20, 1992, be Withdrawn and the parties are directed to file supplemental briefs that comply with the requirements of C.A.R. 28 and 32. Petitioner's initial supplemental brief shall be filed within forty days of the date of this Order. Any answer

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and reply briefs shall be filed in accordance with C.A.R. 31. The supplemental briefs shall address the following issues:

1. Did the respondents violate the petitioner, Duc Van Le, and the class members rights under section 504 of the Rehabilitation Act of 1972, 29 U.S.C. § 794 (1988), or the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution by granting benefits to the elderly, blind, physically disabled and developmentally disabled and not to the mentally ill?

2. Does Congress have the power to enact a public welfare revenue sharing program that permits the states to target discrete groups for certain services?

a. If so, is the Medicaid statute, 42 U.S.C.A. § 1396 (West 1992), and the regulations pursuant thereto, an exercise of that power?

b. Did Congress intend, by passage of either section 504 of the Rehabilitation Act of 1972, 29 U.S.C. § 794 (1988), or section 202 of the Americans with Disabilities Act of 1972, 42 U.S.C.A. 12132 (West 1992), to prohibit such targeting and to thereby effectively amend the Medicaid statute?

3. Did the enactment of the Civil Rights Restoration Act of 1987, Pub. L. No. 100-259, 102 Stat. 28 (1988), overturn the rationale of United States Department of Transportation v. Paralyzed Veterans, 477 U.S. 597 (1986), and other United States Supreme Court cases?

4. Did the enactment of section 2 of the Americans with Disabilities Act of 1990, 42 U.S.C.A. §§ 12101 (West 1992), cause Duc Van Lee and the class to become a suspect class protected by the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution?

5. Did the enactment of section 202 of the Americans with Disabilities Act of 1990, 42 U.S.C.A. § 12132 (West 1992), have retroactive application?

a. If so, did the respondents violate section 202 by failing to provide HCBS benefits to Duc Van Le and the members of the class?

BY THE COURT, EN BANC, May 28, 1992.

JUSTICE VOLLACK does not participate.

cc:

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Honorable Edward E. Carelli
c/o Honorable John N. McMullen
Denver District Court
City and County Building
1437 Bannock Street
Denver, CO 80202

EXHIBIT C

First Regular Session

Fifty-ninth General Assembly

LLS NO. 93-0872.01D PRK

SENATE BILL 93-

246

STATE OF COLORADO

HEALTH, ENVIRONMENT WELFARE & INSTITUTIONS

BY SENATORS Wham, Bird, Rizzuto, and Traylor; also REPRESENTATIVES Romero and Owen.

A BILL FOR AN ACT

CONCERNING THE AUTHORITY TO IMPLEMENT A HOME AND COMMUNITY-BASED SERVICES PROGRAM FOR PERSONS WITH MAJOR MENTAL ILLNESSES AS PROVIDED BY FEDERAL WAIVER.

Bill Summary

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments which may be subsequently adopted.)

Authorizes the state department of social services to request a waiver from the federal government for a home and community-based services program for persons with major mental illnesses. Requires that the program be implemented in accordance with waiver provisions. Makes services available to persons with mental illnesses, who would otherwise require nursing facility care, and who are otherwise eligible for the state medical assistance program. Allows for eligibility to be restricted to persons who meet the level of services provided in a nursing facility so long as such criteria is allowed under the federal waiver. Allows the state board of social services to establish the types of services available to eligible persons, but requires that such services be consistent with the federal waiver. Sets forth the powers and duties of the departments of social services and institutions. Provides for the scheduled repeal of the program.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Part 6 of article 4 of title 26, Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SUBPART to read:

SUBPART 5

Capital letters indicate new material to be added to existing statute.
Dashes through the words indicate deletions from existing statute.

HOME AND COMMUNITY-BASED SERVICES

FOR PERSONS WITH MAJOR MENTAL ILLNESSES

26-4-671. Short title - citation. THIS SUBPART 5 SHALL BE COMPRISED OF SECTIONS 26-4-671 TO 26-4-676 AND MAY BE CITED AS SUBPART 5. THE TITLE OF THIS SUBPART 5 SHALL BE KNOWN AND MAY BE CITED AS THE "HOME AND COMMUNITY-BASED SERVICES FOR PERSONS WITH MAJOR MENTAL ILLNESSES ACT".

26-4-672. Legislative declaration - no entitlement created. (1) THE GENERAL ASSEMBLY HEREBY FINDS AND DECLARES THAT THE PURPOSE OF THIS SUBPART 5 IS TO PROVIDE, UNDER FEDERAL AUTHORIZATION AND SUBJECT TO AVAILABLE APPROPRIATIONS, HOME AND COMMUNITY-BASED SERVICES FOR PERSONS WITH MAJOR MENTAL ILLNESSES.

(2) NOTHING IN THIS SUBPART 5 SHALL BE CONSTRUED TO ESTABLISH THAT ELIGIBLE PERSONS AS DEFINED IN SECTION 26-4-673 (1) ARE ENTITLED TO RECEIVE SERVICES FROM THE DEPARTMENT OF SOCIAL SERVICES OR THE DEPARTMENT OF INSTITUTIONS. THE PROVISION OF ANY SERVICES PURSUANT TO THIS SUBPART 5 SHALL BE SUBJECT TO FEDERAL WAIVER AUTHORIZATION AND AVAILABLE APPROPRIATIONS.

26-4-673. Definition. AS USED IN THIS SUBPART 5, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "ELIGIBLE PERSON" MEANS A PERSON:

(a) WHO HAS A PRIMARY DIAGNOSIS OF MAJOR MENTAL ILLNESS, AS SUCH TERM IS DEFINED IN THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS USED BY THE MENTAL HEALTH PROFESSION, AND

INCLUDES SCHIZOPHRENIC, PARANOID, MAJOR AFFECTIVE, AND SCHIZOAFFECTIVE DISORDERS, AND ATYPICAL PSYCHOSIS, BUT DOES NOT INCLUDE DEMENTIA, INCLUDING ALZHEIMER'S DISEASE OR RELATED DISORDERS;

(b) WHO IS IN NEED OF THE LEVEL OF CARE AVAILABLE IN A NURSING FACILITY;

(c) WHO IS CATEGORICALLY ELIGIBLE FOR MEDICAL ASSISTANCE, OR WHOSE GROSS INCOME DOES NOT EXCEED THREE HUNDRED PERCENT OF THE CURRENT FEDERAL SUPPLEMENTAL SECURITY INCOME BENEFIT LEVEL, AND WHOSE RESOURCES DO NOT EXCEED THE LIMIT ESTABLISHED FOR INDIVIDUALS RECEIVING A MANDATORY MINIMUM STATE SUPPLEMENTATION OF SUPPLEMENTAL SECURITY INCOME BENEFITS; AND

(d) FOR WHOM THE COST OF SERVICES NECESSARY TO PREVENT NURSING FACILITY PLACEMENT WOULD NOT EXCEED THE AVERAGE COST OF NURSING HOME CARE.

26-4-674. Relationship to single entry point for long-term care. THE HOME AND COMMUNITY-BASED SERVICES PROGRAM FOR PERSONS WITH MAJOR MENTAL ILLNESSES SHALL NOT BE CONSIDERED A PUBLICLY FUNDED LONG-TERM CARE PROGRAM FOR THE PURPOSES OF SECTIONS 26-4-521 TO 26-4-525, CONCERNING THE SINGLE ENTRY POINT SYSTEM, UNLESS AND UNTIL THE DEPARTMENTS OF SOCIAL SERVICES AND INSTITUTIONS PROVIDE IN THE MEMORANDUM OF UNDERSTANDING BETWEEN THE DEPARTMENTS FOR THE INCLUSION OF THE PROGRAM IN THE SINGLE ENTRY POINT SYSTEM.

26-4-675. Implementation of program for mentally ill authorized - federal waiver - duties of the department of social

services and the department of institutions. (1) THE STATE DEPARTMENT IS HEREBY AUTHORIZED TO SEEK ANY NECESSARY WAIVER FROM THE FEDERAL GOVERNMENT TO DEVELOP AND IMPLEMENT A HOME AND COMMUNITY-BASED SERVICES PROGRAM FOR PERSONS WITH MAJOR MENTAL ILLNESSES. THE PROGRAM SHALL BE DESIGNED TO PROVIDE HOME AND COMMUNITY-BASED SERVICES TO ELIGIBLE PERSONS. ELIGIBILITY MAY BE LIMITED TO PERSONS WHO MEET THE LEVEL OF SERVICES PROVIDED IN A NURSING FACILITY AND SERVICES FOR ELIGIBLE PERSONS MAY BE ESTABLISHED IN STATE BOARD OF SOCIAL SERVICES RULES TO THE EXTENT SUCH ELIGIBILITY CRITERIA AND SERVICES ARE AUTHORIZED OR REQUIRED BY FEDERAL WAIVER.

(2) THE DEPARTMENT OF SOCIAL SERVICES AND THE DEPARTMENT OF INSTITUTIONS SHALL PROVIDE A SYSTEM OF REIMBURSEMENT FOR SERVICES PROVIDED PURSUANT TO THIS SUBPART 5 WHICH ENCOURAGES THE MOST COST-EFFECTIVE PROVISION OF SERVICES.

(3) THE DEPARTMENT OF SOCIAL SERVICES AND THE DEPARTMENT OF INSTITUTIONS SHALL, SUBJECT TO APPROPRIATION, USE AVAILABLE FEDERAL, STATE, LOCAL, OR PRIVATE FUNDS, INCLUDING BUT NOT LIMITED TO, MEDICAID FUNDS AVAILABLE UNDER TITLE XIX OF THE FEDERAL "SOCIAL SECURITY ACT", AS AMENDED, TO CARRY OUT THE PURPOSES OF THIS SUBPART 5.

(4) THE DEPARTMENT OF SOCIAL SERVICES MAY INCLUDE IN THE MEMORANDUM OF UNDERSTANDING WITH THE DEPARTMENT OF INSTITUTIONS PROVISIONS THAT ALLOW THE DEPARTMENT OF INSTITUTIONS TO CERTIFY AGENCIES AS MEDICAID PROVIDERS FOR THE PURPOSES OF THIS SUBPART 5, TO ADOPT FISCAL AND ADMINISTRATIVE PROCEDURES, TO REVIEW

PLANS OF CARE, TO RECOMMEND REIMBURSEMENT RATES, AND TO MAKE RECOMMENDATIONS REGARDING THE SCOPE, DURATION, AND CONTENT OF PROGRAMS AND THE ELIGIBILITY OF PERSONS FOR SPECIFIC SERVICES PROVIDED PURSUANT TO THIS SUBPART 5, AND TO FULFILL ANY OTHER RESPONSIBILITIES NECESSARY TO IMPLEMENT THIS SUBPART 5. HOWEVER, THE PROVISIONS SHALL BE CONSISTENT WITH THE DESIGNATION OF THE DEPARTMENT OF SOCIAL SERVICES AS THE SINGLE STATE AGENCY IN SECTION 26-4-104.

(5) THE STATE BOARD OF SOCIAL SERVICES SHALL PROMULGATE SUCH RULES AND REGULATIONS REGARDING THIS SUBPART 5 AS ARE NECESSARY TO FULFILL THE OBLIGATIONS OF THE DEPARTMENT OF SOCIAL SERVICES AS THE SINGLE STATE AGENCY TO ADMINISTER MEDICAL ASSISTANCE PROGRAMS IN ACCORDANCE WITH TITLE XIX OF THE FEDERAL "SOCIAL SECURITY ACT", AS AMENDED.

(6) THE DEPARTMENT OF INSTITUTIONS SHALL PROMULGATE SUCH RULES AS ARE NECESSARY TO PERFORM ITS FUNCTION PURSUANT TO THIS SUBPART 5. SUCH RULES SHALL BE PROMULGATED IN ACCORDANCE WITH SECTION 24-4-103, C.R.S., AND SHALL BE CONSISTENT WITH THE STATE BOARD OF SOCIAL SERVICES RULES.

(7) IN THE EVENT A DIRECT CONFLICT ARISES BETWEEN THE RULES AND REGULATIONS OF THE DEPARTMENT OF SOCIAL SERVICES PROMULGATED PURSUANT TO SUBSECTION (5) OF THIS SECTION AND THE RULES AND REGULATIONS OF THE DEPARTMENT OF INSTITUTIONS PROMULGATED PURSUANT TO SUBSECTION (6) OF THIS SECTION, REGARDING IMPLEMENTATION OF THIS SUBPART 5, THE RULES AND REGULATIONS OF THE DEPARTMENT OF SOCIAL SERVICES SHALL CONTROL.

26-4-676. Implementation of subpart contingent upon receipt of federal waiver - repeal of subpart. (1) THE IMPLEMENTATION OF THIS SUBPART 5 IS CONDITIONED UPON THE ISSUANCE OF NECESSARY WAIVERS BY THE FEDERAL GOVERNMENT AND AVAILABLE APPROPRIATIONS. THE PROVISIONS OF THIS SUBPART 5 SHALL BE IMPLEMENTED TO THE EXTENT AUTHORIZED BY FEDERAL WAIVER. THE STATE DEPARTMENT SHALL PROPOSE LEGISLATION THAT CONFORMS WITH THE WAIVER PROVISIONS NO LATER THAN THE NEXT REGULAR LEGISLATIVE SESSION FOLLOWING THE ISSUANCE OF THE WAIVER.

(2) PROVISIONS OF THIS SUBPART 5 THAT ARE APPROVED BY THE FEDERAL GOVERNMENT AND ARE AUTHORIZED BY FEDERAL WAIVER SHALL REMAIN IN EFFECT ONLY FOR SO LONG AS SPECIFIED IN THE FEDERAL WAIVER, UNLESS OTHERWISE EXTENDED BY THE FEDERAL GOVERNMENT. THE STATE DEPARTMENT SHALL PROVIDE WRITTEN NOTICE TO THE REVISOR OF STATUTES OF THE FINAL TERMINATION DATE OF THE WAIVER, AND THIS SUBPART 5 SHALL BE REPEALED, EFFECTIVE JULY 1 OF THE YEAR IN WHICH THE WAIVER IS TERMINATED.

(3) THIS SUBPART 5 IS REPEALED, EFFECTIVE JULY 1, 1998, UNLESS OTHERWISE REPEALED PRIOR TO SAID DATE IN ACCORDANCE WITH SUBSECTION (2) OF THIS SECTION.

26-4-677 to 26-4-680. (Reserved)

SECTION 2. The introductory portion to 26-4-622 (1), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended to read:

26-4-622. Legislative declaration. (1) ~~It is the intent of the general assembly to provide cost-effective services in~~

~~the least restrictive setting to individuals who are mentally ill. It is from that philosophy that the general assembly authorized and the state implemented a home and community-based services program under the auspices of a federal medicaid waiver. Inasmuch as the federal government has been unwilling to continue Colorado's waiver for mentally ill persons, the enabling state statutory provisions for that medicaid funded program are hereby removed. However, the general assembly has an ongoing interest in examining the needs of those who are in need of long-term care because of their mental illness and in the most cost-effective mental health and supportive services as may be necessary to allow the greatest degree of independence. In furtherance of this intent, the department of institutions is charged to report to the general assembly on or before January 1, 1991, on any additional statutory, budget, or administrative modifications that will facilitate the goal of home and community-based care for the mentally ill.~~ The general assembly hereby finds and declares that it is the purpose of this article to provide services for the developmentally disabled which would foster the following goals:

SECTION 3. 26-4-302 (1) (c), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW SUBPARAGRAPH to read:

26-4-302. Basic services for the categorically needy - optional services. (1) The following are services for which federal financial participation is available and which Colorado

has selected to provide as optional services under the medical assistance program:

(c) Home and community-based services, as specified in part 6 of this article, which include:

(IV) HOME AND COMMUNITY-BASED SERVICES FOR PERSONS WITH MAJOR MENTAL ILLNESSES, AS SPECIFIED IN SUBPART 5 OF PART 6 OF THIS ARTICLE.

SECTION 4. 26-4-303 (1), Colorado Revised Statutes, 1989 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

26-4-303. Optional programs with special state provisions. (1) This section specifies programs developed by Colorado to increase federal financial participation through selecting optional services or optional eligible groups. These programs include but are not limited to:

(d.5) THE HOME AND COMMUNITY-BASED SERVICES PROGRAM FOR PERSONS WITH MAJOR MENTAL ILLNESSES, AS SPECIFIED IN SUBPART 5 OF PART 6 OF THIS ARTICLE;

SECTION 5. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

EXHIBIT D

STATE OF COLORADO

DEPARTMENT OF SOCIAL SERVICES
1575 Sherman Street
Denver, Colorado 80203-1714
Phone (303) 866-5700

Roy Romer
Governor
[redacted]
Karen Beye
Executive Director

April 29, 1993

Mr. Gary Wilks
Associate Regional Administrator
Department of Health and Human Services
Division of Medicaid
Regional Office
Room 1185, Federal Office Building
Denver, Colorado 80204

Dear Mr. Wilks:

Attached is one original and six (6) copies, for your approval, of the request of the State of Colorado for a Home and Community-Based Services Waiver for persons with Major Mental Illness. We are requesting that this waiver be effective July 1, 1993 to coincide with the State fiscal year.

This waiver will enable Colorado to serve individuals with major mental illness who are in nursing facilities, as approved by the PASSAR process, to be served in the community with Home and Community Based services at a cost equal to or less than the cost of nursing facilities. Colorado currently is under court order to provide these services to this target group in the same way that services are provided to the elderly, blind and disabled. The court found that it is a violation of the equal protection provisions of the United States Constitution to provide these services to one target group and not to provide the services to another target group. As these individuals are legally in nursing facilities, as defined by the Federal Regulation under the Nursing Home Reform Act, waiver services should also be available to individuals with major mental illness.

We look forward to hearing from you regarding any questions you may have. You may contact Bruce Berger, Division of Mental Health, at (303) 762-4069.

Sincerely,

Karen Beye
Executive Director

COLORADO HCBS WAIVER APPLICATION

FOR INDIVIDUALS WITH MAJOR MENTAL ILLNESS

WAIVER REQUESTS UNDER

SECTION 1915(c)

OF THE

SOCIAL SECURITY ACT

HOME AND COMMUNITY-BASED SERVICES WAIVER REQUEST

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SECTION 1915(c) WAIVER REQUEST

1. The State of Colorado requests a Medicaid home and community based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

   This is a request for a model waiver.

   a.___ Yes b.__X__ No

   If yes, the State assures that no more than 200 individuals will be served on this waiver at any one time.

   This waiver is requested for a period of (check one):

   a__X__ 3 years (Initial waiver) b._____ 5 years (Renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following level(s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

   a.__X__ Nursing facility (NF)

   b.___ ICF for the mentally retarded or persons with related conditions (ICF/MR)

   c.___ Hospital

   d.___ NF (served in hospital)

   e.___ ICF/MR (served in hospital)

3. This waiver is limited to the following target group of recipients:

   a.___ aged (age 65 and older)

   b.___ disabled

   c.___ aged and disabled

d. ___ mentally retarded

e. ___ developmentally disabled

f. ___ mentally retarded and developmentally disabled

g. _X_ chronically mentally ill

4. Additional targeting restrictions (specify):

a. _X_ Eligibility is limited to the following age groups (specify):
18 and Older

b. _X_ Eligibility is limited to individuals with the following disease(s) or condition(s) (specify):

Waiver services will be limited to individuals who have a current primary diagnosis of major mental illness (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3ed edition (DSM-IIIR)) limited to schizophrenic, paranoid, major affective, schizoaffective disorders and atypical psychosis and does not have a diagnosis of dementia (including Alzheimer's disease or a related disorder).

c. ___ Other (specify):

d. ___ This waiver is limited to mentally retarded/developmentally disabled individuals who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of care of an ICF/MR.

5. A waiver of the statewideness requirements set forth in section 1902 (a)(1) of the Act is requested.

a. ___ yes b. _X_ no

If yes, waivers will apply to individuals only in the following geographic areas or political subdivisions (specify):

6. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to waiver recipients.

7. The State requests that the following home and community-based services, as described and defined in appendix B.1 of this request, be included under this waiver:

a. N/A Case management: Case management-type services will be provided as part of general administration, for efficient administration of the state plan.

b. X Homemaker

c. ___ Home health services

d. X Personal care services

e. X Respite care

f. X Adult day care

g. ___ Habilitation

___ Residential habilitation

___ Day habilitation

___ Prevocational services

___ Supported employment services

___ Educational services

h. X Home modifications

i. ___ Skilled nursing

j. X Transportation

k. ___ Specialized medical equipment and supplies

l. ___ Chore services

m. ___ Personal Emergency Response Systems

n. ___ Companion Services

o. ___ Private Duty Nursing

p. ___ Extended State plan services:
Check all that apply:

___ Physician services

___ Home health care services

___ Physical therapy services

___ Occupational therapy services

___ Speech, hearing and language services

___ Prescribed drugs

___ Other (specify):

q. _X_ Other services (specify): Alternative Care Facility Services

8. The State of Colorado assures that adequate standards for each provider of services under the waiver exist. The State further assures that all provider standards will be met.

9. Eligibility. In addition to meeting targeting criteria indicated in items 2 and 3 of this request, an individual must meet the Medicaid eligibility criteria set forth in appendix C of this request.

10. A waiver of section 1902 (a) (10) (C) (i) (III) of the Act is requested to use institutional deeming rules when determining eligibility for the individual.

a. ___ yes b. _X_ no

11. An individual written plan of care will be developed by qualified individuals for each recipient under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not

included in the individual written plan of care.

12. Waiver services will not be furnished to recipients while they are inpatients of a hospital, NF, or ICF/MR.

13. Federal financial participation will not be available in expenditures for the cost of room and board, except when provided as part of respite care in a facility approved by the State that is not a private residence. Meals provided under any waiver service (or combination of services) will not constitute a "full nutritional regimen" (3 meals a day).

14. The State will refuse to offer home and community-based services to any recipient for whom it can reasonably be expected that the cost of home or community-based services furnished to that recipient would exceed the cost of a level of care referred to in item 2 of this request.

a. X yes b. ___ no

15. The Medicaid agency provides the following assurances to HCFA:

a. Necessary safeguards have been taken to protect the health and welfare of the recipients of the services. Those standards include:

1. adequate standards for all types of providers that provide services under the waiver (see Appendix B);

2. assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

3. assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and

community-based services.

c. When a recipient is determined to be likely to require a level of care indicated in item 2 of this request, the recipient or his or her legal representative will be:

1. informed of any feasible alternatives under the waiver; and

2. given the choice of either institutional or home and community-based services.

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to beneficiaries who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditures for home and community-based and other Medicaid services provided to individuals under the waiver will not, in any year of the waiver period, exceed the amount that would be incurred by Medicaid for these individuals in the setting(s) indicated in item 2 of this request, in the absence of the waiver.

g. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the recipients. The information will be consistent with a data collection plan designed by HCFA.

h. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984,

P.L. 98-502.

a. ___X___ yes b. _____ no

16. The agency will provide for an independent assessment of its waiver (except as HCFA may otherwise specify for particular waivers) that evaluates the quality of care provided, access to care, and cost-effectiveness. The results of the assessment will cover all but the last fiscal year of the waiver, and will be submitted to HCFA 90 days prior to the expiration of the approved waiver.

17. The State of Colorado assures that it will have in place a formal system by which it ensures the health and welfare of the recipients, through monitoring of the quality control procedures described in this waiver document. Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures the State will ensure the quality of services furnished under the waiver and the State plan to waiver recipients. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiency.

18. An effective date of July 1, 1993 is requested.

19. The State contact person for this request is Bruce Berger who can be reached by telephone at (303) 762-4069.

20. This document, together with Appendices A through F, and all attachments, constitutes the State of Colorado's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be made in writing and will be submitted by the State Medicaid agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature:

Print name: Karen Beye

Title: Executive Director

Date:

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

Check one:

___ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

__X__ The waiver will be operated and overseen by the Department of Institutions, Division of Mental Health, a separate agency of the State. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

____ The waiver will be operated and overseen by _____, a separate division within the Medicaid agency. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file in the Medical Assistance Unit at the Medicaid agency.

The waiver program will formally interact with the following programs funded under other State or Federal authorities (specify): The Single Entry Point Program, and the providers of mental health services under the Rehabilitation Option.

APPENDIX B-1

DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver:

a. N/A Case management: services which will assist waiver recipients in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case management-type services will be provided as general administration, for efficient administration of the State plan.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the recipient's plan of care.

X yes ___ no

Additionally, case managers shall initiate and oversee the process of assessment and reassessment of recipient level of care and the review of plans of care at such intervals as are specified in appendices C & D of this request.

X yes ___ no

___ Other Service Definition (specify): Case management will be provided as general administration, for the efficient administration of the state plan.

Educational and professional qualifications of case managers are specified in Appendix B-2.

b. X Homemaker: services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or

others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities. These standards are included in Appendix B-2.

_____ Other Service Definition (Specify):_____

c. ___Home health aide services: services defined in 42 CFR 440.70 with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan. Provider qualifications are specified in Appendix B-2.

_____ Other Service Definition (Specify):_____

d. __X__ Personal care services: assistance with eating, bathing, dressing, personal hygiene, activities of daily living. May include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are essential to the health and welfare of the recipient. Personal care providers must meet State standards for this service. These standards are included in Appendix B-2.

1. Services provided by family members. Check one:

_____Payment will not be made for personal care services furnished by a member of the recipient's family.

__X__ Personal care providers may be members of the recipient's family. Payment will not be made for services furnished to a minor by the recipient's parent (or step-parent), or to a recipient by that recipient's spouse. Check one:

__X__ Family members who provide personal care services must meet the same standards as providers who are unrelated to the recipient. These standards are found in Appendix B-2.

_____Standards for family members providing personal care services differ from those for other providers of this service. The standards for family members are found in Appendix B-2.

2. Supervision of personal care providers will be furnished by:

___a registered nurse, licensed to practice nursing in the State

___ case managers

__X__ other (specify): Supervisory staff of personal care agencies.

3. Frequency or intensity of supervision:

___ as indicated in the plan of care

__X__ other (specify): At least once every three months.

4. Relationship to State plan services. Check one:

__X__ Personal care services are not provided under the approved State plan.

___ Personal care services are included in the State plan, but with limitations. The waivered service will serve as an extension of the State plan service, in accordance with documentation provided in Appendix F of this waiver request.

___ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

___ Other service definition (specify):_____

e. __X__ Respite care: services given to individuals unable to care for themselves; provided on a short-term basis because of the absence or need for relief of those persons normally providing the care. FFP will not be claimed for the cost of room and board except when provided as part of respite care in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s):

___ Recipient's home or place of residence

___ Foster home

_X_ Facility approved by the State which is not a private residence.

The State will apply the following limits to respite care provided in a facility.

_X_ Respite care provided in a facility which is not a private residence shall be limited to _30_ days per recipient per waiver year.

___ Respite care will be provided in accordance with the plan of care. There are no set limits on the amount of facility-based respite care which may be utilized by a recipient.

Respite care will be provided in the following type(s) of facilities.

___ Hospital

_X_ NF

___ ICF/MR

___ Group home

___ Licensed respite care facility

_X_ Other (specify): Alternative Care Facility

Qualifications of the providers of respite care services are included in Appendix B-2. Applicable Keys amendment standards are included in Appendix B-3.

_____ Other Service Definition (Specify):_____

f. _X_ Adult day care: services furnished 3 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the client. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day). Physical, occupational and speech therapies indicated in the recipients' plans of care will be furnished as component parts of this service.

Transportation between the recipient's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services.

_____ YES _____X_____ NO

Qualifications of the providers of Adult Day Health services are contained in Appendix B-2.

_____ Other Service Definition (Specify):_____

g. ___ Habilitation: services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

___ Residential habilitation: assistance with acquisition, retention or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Payments for residential habilitation are not made for room and board, the cost of administering a facility or group home, or the costs of facility maintenance, upkeep, and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the recipient's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

____ Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the recipient resides. Services shall normally be furnished 4 or more hours per day on a regularly scheduled basis, for 1 or more days per week, unless provided as an adjunct to other day activities included in the recipient's plan of care. Day habilitation services shall focus on enabling the individual to attain his or her maximum functional level, and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

_____Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Education of the Handicapped Act. Services aimed at preparing an individual for paid or unpaid employment, but which are not job task oriented. Includes teaching such concepts as compliance, attending, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). Prevocational services

are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.

Check one:

___ Clients will not be compensated for prevocational services.

___ When compensated, clients are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the client's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142; and

2. The client has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

___ Educational services, which consist of special education and related services as defined in sections (16) and (17) of the Education of the Handicapped Act, to the extent to which they are not available under a program funded by that Act. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142; and

2. The client has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

___ Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain

paid work by waiver clients, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by waiver recipients as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services rendered under the waiver are not available under a program funded by either the Rehabilitation Act of 1973, or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or P.L. 94-142; and

2. The client has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer of beneficiaries to encourage or subsidize employer's participation in a supported employment program;

2. Payments that are passed through to beneficiaries of supported employment programs; or

3. Payments for vocational training that is not directly related to a beneficiary's supported employment program.

Transportation will be provided between the recipient's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the recipient receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

_____ YES _____ NO

Qualifications of the providers of habilitation services are found at Appendix B-2.

_____ Other Service Definition (Specify):_____

h. X Home modifications: those physical adaptations to the home, required by the recipient's plan of

care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the recipient would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the recipient, but shall exclude those adaptations or improvements to the home which are not of direct medical or remedial benefit to the waiver client, such as carpeting, roof repair, central air conditioning, etc. All services shall be provided in accordance with applicable State or local building codes.

This service is necessary to prevent the institutionalization of the recipient. The cost-effectiveness of this service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

_____ Other Service Definition (Specify):_____

i. __ Skilled nursing; services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. The provision of this service will prevent institutionalization of the recipient. Licensure and certification standards for the providers of skilled nursing services are included in Appendix B-2. The cost-effectiveness of this service is demonstrated in Appendix G.

_____ Other Service Definition (Specify):_____

j. X Non-Medical Transportation: service offered in order to enable waiver recipients to gain access to waiver and other community services and resources, required by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services offered under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the recipient's plan of care. By enabling recipients to gain physical access to community services, institutionalization can be avoided. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized. In no case will family members be reimbursed for the provision of transportation services under the waiver. Qualifications of the providers of this service are included in Appendix B-2. The cost-effectiveness of this service is demonstrated in Appendix G.

_____ Other Service Definition (Specify):_____

k. ___ Specialized Medical Equipment and Supplies: Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable recipients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the recipient. This service is necessary to prevent institutionalization. All items shall meet applicable standards of manufacture, design and installation. The cost-effectiveness of this service is demonstrated in Appendix G. Provider qualifications are included in Appendix B-2.

_____ Other Service Definition (Specify):_____

l.___ Chore Services. Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access inside the home for the recipient, and shoveling snow to provide access and egress. Chore services are necessary to prevent institutionalization of the client. These services will be provided only in cases where neither the client, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service. The cost effectiveness of chore services is demonstrated in Appendix G. Provider qualifications are found in Appendex B-2.

m.___ Personal Emergency Response Systems (PERS). PERS is an electronic device which enables certain high-risk patients to secure help in the event of an emergency. The client may also wear a portable "help" button to allow for mobility. The system is connected to a patient's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caretaker for extended periods of time, and who would otherwise require extensive routine supervision. By providing immediate access to assistance, PERS serves to prevent institutionalization of these individuals. The cost effectiveness of this service is demonstrated in Appendix G.

n.___ Companion Services. Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion

services does not entail hands-on medical care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the client. This service is provided in accordance with a therapeutic goal in the plan of care, and is not merely diversional in nature. This service is necessary to prevent institutionalization. Provider qualifications are located in Appendix B-2. The cost effectiveness of this service is demonstrated in Appendix G.

o.__ Private Duty Nursing. Private Duty Nursing services consist of individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of the State's Nurse Practice Act. These services are provided to an individual at home. Private Duty Nursing services are necessary to prevent institutionalization. The cost effectiveness of this service is demonstrated in Appendix G. Provider qualifications are found in Appendix B-2.

p. __ The following services, available through the approved State plan, will be provided, except that the limitations specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of service(s) and cost-effectiveness are demonstrated in Appendix G. Service expansions are necessary in order to provide the amount of care necessary to prevent institutionalization.

Check all that apply:

___ Physician services

___ Home health care services

___ Physical therapy services

___ Occupational therapy services

___ Speech, hearing and language services

___ Prescribed drugs

___ Other(specify):

q. _X_ Other Services (specify): Alternative Care Facilities are licensed personal care boarding homes in which homemaking and personal care services are provided under the waiver.

The qualifications for the providers of each listed "other" service are found at Appendix B-2. The cost-effectiveness of each service is demonstrated in Appendix F.

APPENDIX B-2

PROVIDER QUALIFICATIONS

LICENSURE AND CERTIFICATION CHART

The following chart illustrates the requirements for the provision of each service under the waiver.

Service	Provider Type	License	Certification	Other Standards
Homemaker	Homemaker Agency		8.490	
Personal Care	Personal Care Agency		8.489	
Respite	Nursing Facility Alternative Care Facility	Nursing Facility; personal care boarding home	8.405 et seq. 8.495	
Adult Day Care	Adult Day Care Centers		8.491	
Home Modifications	Building Contractors	As required by local and State law	8.493	All local building codes must be met.
Transportation	Private Vehicle Public Transportation and other providers	As required by State law	8.494	
Alternative Care Facilities	Personal Care Boarding Homes	Personal Care Boarding Home	8.495	

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State of Colorado assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

a. KEYS AMENDMENT ASSURANCE:

The State of Colorado assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. APPLICABILITY OF KEYS AMENDMENT STANDARDS

Check one:

_____ Home and community-based services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

__X__ Keys amendment standards are provided for the following:

FACILITY TYPE	WAIVER SERVICE(S)
1. Alternative Care Facilities	Homemaker, Personal Care, Respite
2. Personal Care Boarding Home	Personal Care

c. COPIES OF KEYS AMENDMENT FACILITY STANDARDS

A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

APPENDIX C - ELIGIBILITY REQUIREMENTS AND PROCEDURES

APPENDIX C-1

MEDICAID ELIGIBILITY GROUPS SERVED

a. Individuals receiving services under this waiver would be eligible for Medicaid if institutionalized and would require institutionalization at a level specified in item 2 of this request in the absence of this waiver.

b. To receive services under this waiver, the individual must meet the following Medicaid eligibility criteria (check all that apply):

1. _X_ SSI recipients

2. ___ AFDC recipients

3. _X_ The special home and community-based optional categorically needy group specified in section 1902(a)(10((A)(ii)(VI) of the Act, to permit the agency to cover individuals who would be eligible for Medicaid if they were in a facility specified in item 2 of this request. This group is eligible for Medicaid in the home or community-based setting solely because they require and receive services under this waiver.

4. _X_ Special income level

The special income level used in this waiver is (check one):

A. _X_ 300 percent of SSI

B. ____ Less than 300 percent of SSI. The special income level for this waiver is (specify):

5. ___ Individuals eligible under section 1924 of the Social Security Act.

6. ___ Medically needy.

7. _X_ Other (specify): Recipients of the Colorado Old Age Pension (OAP) who qualify for federal financial participation in the Colorado Medicaid Program, and who are not under the Colorado Modified Medical Program.

APPENDIX C-2

POST ELIGIBILITY PROCEDURES AND CALCULATIONS

a. Post eligibility treatment of income rules will be applied for individuals eligible under a special income level (whose eligibility is not established under section 1924 of the Act) as specified in (check one):

1. __X__ 42 CFR 435.726 (for use only by States which do not use the 209(b) option).

2. ____ 42 CFR 435.735 (for use only by States which have elected the 209(b) option).

3. ____ Not applicable. This waiver will not serve individuals eligible under a special income level.

b. For individuals receiving home and community based services who are subject to the post eligibility rules (and whose eligibility is not established under section 1924 of the Act), the payment for home and community-based services will be reduced by the amount that remains after deducting the appropriate amounts from the individuals income, in the following order (fill in a dollar or percentage amount):

1. An allowance for the needs of the individual: The amount of current Old Age Pension (OAP) standard plus $20 income disregard amount ($510 for 1993).

2. An allowance for the needs for the spouse at home: The amount of current state Aid to the Needy Disabled (AND) standard ($229 for 1993).

3. An allowance for family members other than spouses: An amount equal to the AFDC standard that would be paid for a family of the same size.

4. Incurred expenses for medical or remedial care not covered under the State plan (including the cost of Medicare and other health insurance premiums).

APPENDIX C-3

SPOUSAL IMPOVERISHMENT

a. Under section 1924 of the Act, the income and resource eligibility rules for individuals under this waiver who have community spouses are as specified in the approved State plan.

b. For waiver recipients whose eligibility is established under section 1924 of the Act, the post-eligibility treatment of income will be in accordance with section 1924(d) of the Act as specified in the approved State plan. After the recipient is determined to be eligible for Medicaid, in determining the amount of the spouses income applicable to payment, there shall be deducted from the income the following amounts in the following order (fill in the amount):

The Personal needs allowance for the recipient of waiver services is N. A.

APPENDIX D - ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

APPENDIX D-1-a

INITIAL EVALUATION

1. Initial evaluation of level of care is performed for deinstitutionalized individuals:

   _X_ Within _10_ days after a request for such evaluation by the individual or legal representative, or referral by other competent authority (such as doctor, discharge planning team, social worker, etc.)

   _X_ At the time of discharge from the institutional setting

   ___ As part of the institutional discharge planning process

   ___ Other (specify):

2. Initial evaluation of level of care is performed for diverted individuals:

   _X_ Within _10_ days after a request for such evaluation by the individual or legal representative, or referral by other competent authority (such as doctor, discharge planning team, social worker, etc.)

   ___ Upon application for nursing home

   ___ As part of the long term care pre-admission screening process required by this State

   _____ Other (specify):

   _____ Not applicable. This waiver will not serve diverted individuals.

APPENDIX D-1-b

QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

Check one:

1. _X_ Initial evaluation of level of care is performed for waiver and institutionalized individuals through a common Pre-Admission Screening (PAS) system. The educational/professional qualifications for evaluators are the same for waiver applicants and applicants for nursing facilities.

2. ___ The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants differ from those of individuals performing this function for applicants for nursing facilities.

   a. The educational/professional qualifications of persons performing initial level of care evaluations for deinstitutionalized individuals are (specify):

   b. The educational/professional qualifications of persons performing initial level of care evaluations for diverted individuals are:

      _____ Same as for deinstitutionalized

      _____ Different than procedures for deinstitutionalized (specify).

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the recipient will take place (at a minimum) according to the following schedule (specify): According to the assigned length of stay, which will never exceed one year and which may be less than 30 days, depending on medical condition.

A description of the procedure(s) used to ensure the performance of reevaluations according to the above schedule is included below.

Case managers are required to obtain new information from the attending physician on the Uniform Long Term Care form (ULTC-100); conduct re-assessment of functional impairments and needs, and submit to the Colorado Foundation for Medical Care (PRO) one month before the end of the length of stay.

b. QUALIFICATIONS OF EVALUATORS PERFORMING REEVALUATIONS

Check one:

_X_ The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

___ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. (Specify.)

c. PROCEDURES FOR DIVERTED RECIPIENTS

The following is a more detailed description of the evaluation and screening procedures used in connection with diverted recipients to assure that the provision of waiver services will be limited to persons who would otherwise receive a level of care indicated in item 2 of this waiver request.

Check one:

___ The evaluation and screening procedures used for diverted individuals are the same as those used for the deinstitutionalized.

_X_ Evaluation and screening procedures used for diverted individuals differ from those used for deinstitutionalized persons. Following is a description of the differences.

All HCBS-MI applicants must require the skilled and maintenance services provided in a nursing facility, whether they are diverted or deinstitutionalized.

Persons who are leaving a nursing facility to receive HCBS-MI services do not go through the additional screening-in step that is described for HCBS-MI receipients at APPENDIX D-3.

___ Not applicable. This waiver is limited to deinstitutionalized individuals.

APPENDIX D-3

MAINTENANCE OF RECORDS

a. A description of the State's procedure for maintaining records of evaluations and reevaluations of level of care is attached.

These records will be maintained in the following locations (check all that apply):

___ By the Medicaid agency in its central office

___ By the Medicaid agency in district/local offices

___ By the agency designated in Appendix A as having primary authority for the daily operation of the waiver program

_X_ By the case managers

_X_ By the person(s) or agencies designated as responsible for the performance of evaluations and reevaluations, the Professional Review Organization(Colorado Foundation for Medical Care)

_____ By service providers

___ Other (specify):

b. Written documentation of all evaluations and reevaluations will be maintained as described in this appendix for a minimum period of 3 years.

COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

Check one:

1. _X_ Forms used to evaluate level of care for waiver recipients, and the criteria by which the level of care decision is made are the same as for the institutionalized applicants and recipients.

Applicants seeking admission to nursing facilities and to the HCBS-MI program must require the skilled and maintenance services provided in a nursing facility.

All HCBS-MI applicants and recipients at continued stay review will have an additional assessment to further examine their functional impairments to determine their appropriateness for alternative services. The qualifications for those individuals conducting this additional evaluation will be the same as the evaluators for the nursing facilities.

If an applicant is not certified based on the additional assessment, the applicant is referred to the physician advisor to determine if he/she requires the skilled and maintenance services provided in a nursing facility.

2. ___ Forms and/or criteria used in determining level of care for waiver applicants/recipients differ from those used for institutionalized individuals. Attached are copies of the forms used by the State to evaluate level of care. Also attached are copies of the criteria used to determine level of care. All waiver applicants and recipients at continued stay reviews will be evaluated by the PRO to further examine their functional impairments in areas appropriate to individuals with major mental illness to determine thier appropriateness for placement in alternative settings. If an applicant or recipient, based on the PRO's functional assessment scoring meets the defined thresholds scores, he/she may be certified for waiver services.

3. ___ A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of a recipient's need for a level of care indicated in item 2 of this request is attached to this appendix.

LTC SINGLE ENTRY POINT AGENCY INTAKE

Date Referral Received: ____/____/____
mm dd yyyy

Applicant Information

Name: _____
Address: _____
_____
County Code: _____
Phone: (____)_____
Birthdate:__/__/__ Age: _____
Marital Status: Sgl M D W Sex: M F
SS#: _____-_____-_____
Caller is to be informed the social security number will be used for the sole purpose of completing the services' application.
HH#: _____
State ID#: _____
Medicare Claim #:_____
Person legally responsible for applicant:
☐ Self ☐ Parent(s) ☐ Guardian ☐ Other

Current Living Situation:

___Alone
___With parents
___With spouse/others
___With non-relatives
___With non-spouse relatives
___Other: _____

___Congregate setting
___PCBH
___Foster home
___AFC
___ACF
___NF

Referral Source Information

Name: _____
Agency: _____
Address: _____
_____
Phone: (____)_____

Referral Type:

___Self
___Family
___Friend
___Physician
___DSS
___CMA or SEP
___Other _____

___Legal guardian
___Hospital
___Nursing Facility
___Home Health Agency
___AAA
___Community Svc. Agency

Contact Information:

Contact Person: _____
Relationship: _____
Phone: (____)_____
Physician Name: _____
Physician Phone: (____)_____
Current Service Provider: _____
Phone: (____)_____

Presenting Problem:_____
_____
_____
Diagnosis:_____
_____
_____
Pending or Recent Health Care Facility/Home Health Agency/Hospital/Discharge,(Name & Date)
_____

Assistance Indicated: circle all that apply, N = Needed, R = Receiving

Personal Care		Home Management		Professional Services	
Mobility/Transfers	N R	Housing	N R	Guardianship	N R
Bathing/Hygiene	N R	Housekeeping	N R	Nursing services	N R
Dressing	N R	Shopping	N R	Therapy/rehab	N R
Eating	N R	Meal preparation	N R	Case Management	N R
Toileting	N R	Laundry	N R		
Taking medications	N R	Transportation	N R	**Other Services**	
Supervision	N R	Use of telephone	N R	Electronic Monitoring	N R
Caregiver respite	N R	Managing finances	N R	Durable medical equipment	N R
Other: _____	N R	Home modification	N R	Supported employment services	N R
		Other _____	N R	Other_____	N R

Potential Funding Sources: check all that may apply	**Potential Financial Eligibility**
___ V.A. Benefits ___ Medicare, Part A ___ Medicare, Part B ___ Private Health Insurance ___ Public Assistance ___ Medicaid/Pending ___ Medicaid/Approved ___ Medicaid/No application ___ Private pay	Gross Monthly Income: $_____ Sources: Amount: _____ _____ _____ _____ _____ _____ _____ _____ Assets: $ _____

Potential Program Status: circle all that apply, N = Needed, R = Receiving

Community-Based Programs		Residential Alternatives	
Home Care Allowance (HCA)	N R	Adult Foster Care (AFC)	N R
Home and Community Based Services		Alternative Care Facility (ACF)	N R
(HCBS)-Elderly, Blind, Disabled	N R	Congregate Living	N R
HCBS-Persons Living With AIDS	N R	Nursing Facility (ICF/SNF)	N R
Home Health	N R	Personal Care Boarding Home	N R
Hospice	N R	Other: _____	N R
Independent Living Center	N R		
PACE-Total Longterm Care	N R	Other Programs	
Private Duty Nursing	N R	Children's Services	N R
Title III of Older Americans Act	N R	Developmentally Disabled Services	N R
Veterans Administration	N R	Mental Health Services	N R
Vocational Rehabilitation	N R	Model 200	N R
Other: _____	N R	Private Case Management	N R
		Other: _____	N R

INTAKE WORKER'S RECOMMENDATION:

_____ULTC-100 Assessment Needed
_____No **REFERRAL** Needed
_____No **ASSESSMENT** Needed

Referred to:

__Adult Protective Services
__Eligibility
__Private Case Management
__Other Agency: (Name)

Contact Person:

_____
_____
_____
_____

Reasons for Recommendations: _____

_____

_____

APPLICANT ACCEPTS RECOMMENDATION: ____ YES ____ NO ____ UNKNOWN

Intake Completed by:

Signature: _____ Date: ____/____/_____ (mm/dd/yyyy)

Agency: _____ Phone: _____

For HCBS/EBD-PLWA only, complete the following:

I have reviewed the information contained in this preliminary plan and, if found eligible, I choose to accept services in the: ☐ Community ☐ Nursing Home

Date_____ Signature_____

INSTRUCTIONS FOR THE LONG TERM CARE SINGLE ENTRY POINT AGENCY INTAKE FORM

The Intake form is to be completed by the staff person at the Single Entry Point Agency responsible for the Intake function. This form replaces the 114, (the Long Term Care Screen and Program Targeting form) for the HCBS programs and the SS-1, which has been used in the Home Care Allowance program.

This form is used to document information collected during the initial contact with the applicant or someone acting on his or her behalf. The form collects information which the Intake worker uses in making a recommendation to the applicant, agency or family member for further activities on behalf of the applicant, such as an assessment or referral. It includes a place to document the reasons for the worker's recommendation(s) as well as the applicant's acceptance of the recommendation(s).

Record The Date The Referral Is Received.

Applicant Information:

This section of the form collects information about the potential applicant.

Name:	Enter applicant's name
Address:	Enter number, street, town and zip code of the applicant
County code:	Enter the code for the county of residence
Phone:	Enter the applicant's phone number
Birthdate:	Enter the date of birth and the age of the person
Marital status:	Check Sgl (single), M (married), D (divorced), or W (widowed)
Sex:	Circle appropriate response
SS#:	Enter social security number of the applicant and inform caller that the number will only be used for completing this application.
HH#:	Enter the household number, if known
State ID#:	Enter the state identification number as shown on the Medicaid Authorization Card

Person Legally Responsible:

Check the person who is legally responsible for the applicant, i.e. self, parent, guardian or other person

Current Living Situation:

Check the current living situation of the applicant--PCBH means a personal care boarding home, AFC indicates an Adult Foster Care facility, ACF means an Alternative Care Facility and NF is a nursing facility.

Referral Source Information:

Complete the name of the person making the referral; if appropriate, the name of the agency, the address, and the telephone number.

Referral Type: Check the type of referral source.

Contact Information: Enter the name of the person to be contacted in reference to or for assistance with the applicant. Include the relationship of the person to the applicant and the telephone number.

Physician Name: Include the name, telephone number and address of the applicant's physician.

Presenting Problem: Briefly describe the problem or reason for the request for services. If provided, include the diagnosis.

Pending/Recent Health Care Facility/Home Health Agency Discharge:

Enter the name of the facility/agency and the date the discharge is planned or when it occurred.

Assistance Indicated: This section of the form addresses the assistance or services which the applicant or the person acting on his/her behalf indicates are needed or which the applicant needs but is already receiving. Circle all the services which apply to the applicant. For each service, circle N if the service is needed and R if it is being received.

Potential Funding Sources:

Check the funding sources which you feel are potentially available to pay for the assistance or services needed. Check all that may apply.

Potential Financial Eligibility:

If this information is available, write in the monthly gross income of the applicant, the sources of income and the amount of each source. If available, write in the total amount of the applicant's assets.

Potential Program Status:

This section of the form focuses on the programs which the applicant may potentially be eligible for or currently be receiving. The Intake worker should make an assumption, based on the information received, as to what programs the person may need or be receiving, however, this should not be considered as a statement of program eligibility. Circle the programs that apply; **N** is Needed, **R** is received.

Intake Worker's Recommendation:

This section includes the recommendation(s) of the worker as to the next step which needs to be taken on behalf of the applicant--whether an assessment is needed and if no referral or assessment is needed. If the applicant is being referred, check to whom the referral is being made and write in the name of the contact person at the place of the referral.

Reasons For The Recommendation:

Write in the reason(s) for making the recommendation(s) you made for this applicant. Discuss these with the applicant and check whether or not the applicant accepts the recommendation(s). If you are not able to have this communication with the applicant, check the response, "Unknown".

Intake Completed By: The SEP staff person completing the Intake interview should sign this form, complete the name of the agency and the telephone number, and write in the date the Intake was completed.

The last section of this Intake form is only used for HCBS/EBD/PLWA clients.

This section of the form is to be completed later, when completing the assessment process and the ULTC-100. Take this form with you to the home visit, and, after the assessment, have the client sign the statement that they have reviewed the information in the preliminary plan and agree to have the services delivered in either the **community** or in a **nursing facility**. Include the date and the signature. For these programs, this action establishes the start date for the delivery of the services authorized.

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ULTC-100

LONG TERM CARE CLIENT ASSESSMENT CERTIFICATION AND TRANSFER

7/92

_____ ____-____-_____

State Identification Number

Client's Last Name | First | MI

COMPLETE IF MEDICAID PENDING

A. _____ County in which application made

B. __/__/____ MM DD YYYY Date of Medicaid Appliction

Legal/Street Address | M M D D Y Y Y Y Birthdate | (___)___-____ (Area Code) Telephone Number

City, State | Zip Code | Sex: ☐ Male ☐ Female

County of Residence (Print Full Name) | Current Client Assessment Location (Specify Name)

Diagnosis/Medical Problems Requiring Long Term Care with Dates of Onset	Medications/Treatments/Therapies Dosage, Route and Frequency of Medicines	Other Services Required Related to Medical Problems (i.e., oxygen therapy, patient education, observations and monitoring, follow-up care)
1.		
2.		
3.		
4.		
5.		

Is there a mental illness diagnosis? ☐ Yes ☐ No

Is there a developmentally disabled diagnosis? ☐ Yes ☐ No

Demential type diagnosis must be validated by a neurological exam with documentation on this page by the attending physician.

Date of neuro exam: __/__/__/____

History of mental health treatment within past two years? ☐ Yes ☐ No

Is the patient's condition terminal (6 months or less) if illness follows normal progression? ☐ Yes ☐ No ☐ Unknown

Does patient need convalescent care (1 to 120 days) in a nursing facility? ☐ Yes ☐ No

If hospitalized, reason

If hospitalized, admit date __/__/__/____

Diet order

Allergies/sensitivities

Prognosis

Home health agency involvement? ☐ Yes ☐ No

If yes, agency name

If no, is HHA assessment requested? ☐ Yes ☐ No

Recommend next medical appt? ☐ Yes ☐ No

To be seen by:

Date __/__/__/____

I certify this patient has been examined by me and, to the best of my knowledge, all information in the Physician Information Section is true and complete.

Attending/referring physician signature | Printed Name | Phone | M M D D Y Y Y Y Date Signed

Physician signature required for payment of Medicaid LTC services

CO License No.: _____

FACILITY/CASE MANAGER INFORMATION

Facility Name/Case Management Agency | Administrator/Case Manager Signature

Admit Date: __/__/__/____ M M D D Y Y Y Y | Date Signed

Provider Number: _____

(IMT _____) APPROVAL SECTION

CERTIFICATION SECTION

HCA\AFC Payment Authorization

Authorized Amount $_____

Standard of Need +_____

Total Needs Standard $_____

Total Cli. Income -_____

Warrant Amount $_____

Payment Effective __/__/__/____

HCA Paid by Client to: (Check all that apply)

☐ Family member
☐ Spouse ☐ Agency
☐ Non-relative

HCA: hours of paid care needed per week: _____

NON-PRO APPROVAL

☐ Adult Foster Care
☐ Home Care Allowance
☐ Medicaid Home Health
☐ Older American's Act

TARGET GROUP

☐ DD/MR
☐ MH
☐ Frail Elderly (65+)
☐ Physically Disabled (18-64)
☐ Physically Disabled (13-17)

PRO CERTIFICATION

☐ Nursing Facility ___
☐ HCBS-EBD
☐ HCBS-PLWA
☐ Total Longterm Care (TLC)
☐ HCBS-Model 200
☐ Hospice
__ R & B: $_____ /day
☐ ICF-MR
☐ Other

CFMC VALIDATION STAMP

Start Date __/__/__/____

Reviewer ID: ____

__/__/__/____ Date

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CLIENT INTERVIEW

Client: _____

1. How is your hearing? Can you hear talking without a hearing aid or with one if regularly worn? *(wears hearing aid? ( )Yes)* ☐

   0 = Adequate in most situations, (including groups, normal talk, TV, phone.)
   1 = Minimal difficulty when not in quiet listening conditions.
   2 = Hears only in special situations (speaker has to adjust tonal quality and speak distinctly).
   3 = Highly impaired/absence of useful hearing.
   4 = Unable to assess; why?_____

   b. Recent hearing loss? ( )Yes ( )No Retraining program? ( )Yes ( )No

2. How is your vision in good light with corrective lenses, if generally worn? *(lenses? ( )Yes)* ☐

   0 = Sees adequately in most situations (e.g., can see newsprint, medication labels).
   1 = Can see obstacles in path and surrounding environment (e.g., requires large print, can see fingers at arm's length).
   2 = Can find way around with feeling or using cane or other assistive device; can locate objects by hearing or touching them.
   3 = Cannot find way around with feeling or using cane or other assistive device; cannot locate objects without hearing or touching them.
   4 = Unable to assess; why? _____

   b. Recent vision loss? ( )Yes ( )No Retraining program? ( )Yes ( )No

3. a. How often do you have any of the following medical treatments or therapy regime? *(Specify frequency of all that apply. If hospitalized, answer according to need at discharge.)*

_____Blood sugar monitoring	_____Medication monitoring	_____Speech therapy regime
_____Bowel/Bladder program	_____Occupational therapy regime	_____Suctioning
_____Catheter care	_____Ostomy care	_____Tube Feeding
_____Dialysis	_____Oxygen	_____Ventilator Assistance
_____Foot care	_____Physical therapy regime	_____Wound care/dressing
_____Injections	_____Range of motion	changes
_____IV Therapies	_____Respiratory treatment regime	_____Other

   Comments: _____

   b. Who provides the treatments or therapy regime? *(Check all that apply)*
   ___ facility ___agency ___relatives ___other trained caregiver ___self

4. Do you have any skin problems? (i.e., open sores, lesions, signs of infection, chronic skin condition) Describe: _____ ( )Yes ( )No

5. Would you please show me your medications and tell me what they are for? *(List medications, dose, how often taken, reason, prescribing physician. This question will only be asked if person is not in a hospital or nursing facility. Use medication table to record answer.)*

6. In the **LAST SIX MONTHS**,
   a. How many times have you seen a doctor? *(enter total number)* _____
   b. How many times were you admitted to any kind of hospital? _____
   c. How many times did you go to the emergency room? _____
   d. Were you a resident in a nursing facility, convalescent home or similar place? ( )Yes ( )No
   e. Did you enter a drug or alcohol treatment program? ( )Yes ( )No

Hospital/NF/Treatment	Reason	Admission Date	Discharge Date

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Client: _____

7.

CRITICAL ADLs	Client Functional Capacity (Impairment) Independent	Little	Moderate	Severe	Describe Client Functioning (Type of impairment, frequency of need, who helps, and if client uses adaptive equipment, (i e , wheelchairs, canes, walkers) Use this space to justify need for paid care score.	Need for Paid Care (Frequency) None	Weekly	Daily	Twice Daily +
Transfers	0	1	2	3		0	1	2	3
Bladder care	0	1	2	3		0	1	2	3
Bowel care	0	1	2	3		0	1	2	3
BASIC ADLs									
Mobility	0	1	2	3		0	1	2	3
Dressing	0	1	2	3		0	1	2	3
Bathing	0	1	2	3		0	1	2	3
Hygiene	0	1	2	3		0	1	2	3
Eating	0	1	2	3		0	1	2	3
BASIC IADLs									
Meal preparation	0	1	2	3		0	1	2	3
Housework	0	1	2	3		0	1	2	3
Laundry	0	1	2	3		0	1	2	3
Shopping	0	1	2	3		0	1	2	3
SUPPORTIVE									
Medicine management	0	1	2	3		0	1	2	3
Appointment mgmt	0	1	2	3		0	1	2	3
Money management	0	1	2	3		0	1	2	3
Access resources	0	1	2	3		0	1	2	3
Telephone	0	1	2	3		0	1	2	3
SUBTOTALS	(0)	( )	( )	( )		(0)	( )	( )	( )

Functional Capacity Score: _____ **Need for Paid Care Score:** _____

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Client: _____

8. Where would you prefer to have services provided?_____

9. Are you strong enough to get through a normal, daily routine? ☐
   0 = Adequate to complete tasks within reasonable time frame.
   1 = Slightly limited, but able to complete task within a reasonable time frame.
   2 = Limited physical stamina/endurance to complete tasks.
   3 = Does not have physical stamina to complete tasks even with frequent rest.

10. Will/do you routinely require care from another person during the night? ☐
    0 = Independent
    1 = Requires some care, but gets at least five hours of uninterrupted sleep at night or during an eight hour period.
    2 = Requires substantial care, **cannot** get at least five hours of uninterrupted sleep.

11. **In the past year**, have there been any significant events in your life? *(Do not read list. Can read major headings. Check if yes response to item.)* ( )Yes ( )No ( )UK

Illness/Injury:
- ___ Illness in the family
- ___ Injury/accident
- ___ Personal illness
- ___ Falls

Losses:
- ___ Death of spouse
- ___ Death of friend/family member
- ___ Death of a pet
- ___ Loss of vision, hearing
- ___ Loss of mobility
- ___ Loss of job

Changes:
- ___ Change in residence
- ___ Divorce/separation
- ___ Retirement

Threat:
- ___ Financial concerns
- ___ Safety concerns

Victim:
- ___ Victim of assault/theft
- ___ Victim of exploitation
- ___ Victim of abuse/neglect

12. The next questions are a little different than the ones we just finished. We have a standardized way to ask adults about memory problems and we are asking you the same set of questions we are asking others. We know some people have trouble remembering things and you may not know the answers to some of these questions. That is normal. If you do know the answers, they may seem so obvious that you wonder why I am asking. Please give me your answers to these questions. *(Write exactly what client says. Do not ask children these questions. Scoring: correct = 0, incorrect = 1.* Less than 8th grade education? ( )Yes ( )No *Today's Date* _____ *Day of Week* _____

Score	Question	Response
	a. What is the date today? (month/day/year)	
	b. What day of the week is it?	
	c. What is the name of this place?	
	d. What is your telephone number? (street address if no telephone)	
	e. How old are you?	
	f. When were you born? (month/day/year)	
	g. Who is the current president of the United States?	
	h. Who was the president before him?	
	i. What was your mother's maiden name?	
	j. Subtract 3 from 20 and keep subtracting by three all the way down:	

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ASSESSOR EVALUATION

Client: _____

13. How is the person's **Expressive Communication**? (method of conveying oral or written information): 0 = Communicates information and is understood. 1 = Communicates information but is difficult to understand. 2 = Cannot communicate or convey needs. [ ]

    a. Is client's primary language English? ( )Yes ( )No ( )UK
    If no, client's primary language: _____

    b. Describe any problems with communication. _____

14. How is the person's **Receptive Communication**? (method of understanding oral or written information): 0 = Understands information conveyed without difficulty. 1 = Understands information conveyed but has difficulty. 2 = Cannot understand information conveyed. [ ]

    a. Describe any problems with communication. _____

15. Are you concerned about alcohol/drug consumption by client or others in the household? *If yes, describe:* _____ ( )Yes ( )No ( )UK

16. Does the client need 24 hour supervision? (Client cannot be safely left alone.) ( )Yes ( )No ( )UK

17. ***For clients living with caregiver***, how many hours of relief are needed per week for the caregiver? _____Hrs ( )N/A

18. a. Are you concerned about the quality of caregiver/applicant interaction? ( )Yes ( )No ( )UK ( )N/A
    Comments: _____
    b. Do you suspect possible abuse, exploitation or neglect? (*If yes,* make referral to County Protective Services.) Comments: _____ ( )Yes ( )No ( )UK

19. Is the client's living environment (home, facility) adequately safe for client at this time? Consider history of unsafe smoking practices. *(If yes, skip to next question. Should be based on review of checklist in the instructions.)* ( )Yes ( )No ( )UK

    a. *If No,* Could the living environment be safe with feasible modifications? ( )Yes ( )No ( )UK
    b. *If No,* Is client willing to consider a move? ( )Yes ( )No ( )UK
    c. *If No,* Can services be delivered in this environment? ( )Yes ( )No ( )UK
    d. Is a specialist needed for an assessment of the home? ( )Yes ( )No ( )UK

20. **Has the person or does the person** exhibit any behavioral problems which had or could have **harmful outcomes?** *(Check behavior and specify the harmful outcome.)* ( )Yes ( )No ( )UK

    ___ Self neglect
    ___ Safety related (e.g., smoking)
    ___ Gets lost/wanders
    ___ Other _____
    ___ Uncooperative
    ___ Violent/assaultive/physically abusive
    ___ Lack of awareness of own needs

    Describe history and specify outcome: _____
    _____

21. Did you notice or know of any significant cognitive problems? *(Check and specify cognitive problem and indicate frequency.)* ( )Yes ( )No ( )UK

    ___ History of episodic confusion
    ___ Memory Problem
    ___ Disorientation - ___ Frequently loses train of thought in conversation.
    ___ Difficulty paying attention
    ___ Difficulty with learning
    ___ Difficulty recognizing family members or familiar persons

    Describe and specify: _____

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Client: _____

22. Level of consciousness *(mental alertness)*: ☐
    0 = Alert
    1 = Lethargic
    2 = Stupor
    3 = Responds only to audio/visual stimulation
    4 = Responds only to touch/pain stimulation
    5 = No response to stimuli

23. Are you concerned that person has any of the following problems with medications? ( )Yes ( )No ( )UK
    (Check all that apply.)

    ___ Not taking medicine on time
    ___ Not taking prescription medicine due to cost
    ___ Refusing to take medications
    ___ Needs supervision to correctly take medications daily, weekly
    ___ Not getting prescription properly filled
    ___ Taking prescriptions from several doctors
    ___ Not taking proper number of medicines
    ___ Retaining outdated medications

24. Does the person display any problematic thought content such as hallucinations, homicidal, delusions, and suicidal? *If yes,* describe severity/frequency within last 6 months and any medication regime management. ( )Yes ( )No ( )UK
    Describe:_____

25. Client's Current Living Situation *(if hospitalized, previous arrangement)* ☐
    1 = Alone
    2 = With spouse/spouse & others
    3 = With non-spouse relative
    4 = With non-relatives
    5 = Licensed PCBH (observed)
    6 = Unlicensed PCBH
    7 = AFC (certified, observed)
    8 = Non-certified AFC
    9 = ACF (certified, observed)
    10 = Non-certified ACF
    11 = Nursing facility
    12 = Other_____

26. Location of Assessment: ☐
    1 = Applicant's private residence/home
    2 = Nursing home
    3 = Hospital/other health care facility
    4 = Assisted living facility
    5 = Agency office
    6 = Relative's home
    7 = Other, describe: _____
    _____

27. Present at interview: ☐
    1 = Applicant only
    2 = Applicant and caregiver(s)
    3 = Applicant and others
    4 = Caregiver(s) only
    5 = Other

28. Who provided most of the interview information? ☐
    1 = Applicant
    2 = Caregiver
    3 = Applicant and Caregiver equally
    4 = Medical record
    5 = Facility staff
    6 = Other

Comments: . . . . . .

. . . . . .

. . . . . .

. . . . . .

Assessor:_____ **Date:**_____
Signature **M M / D D / Y Y Y Y**

Agency: _____ **Phone:**_____

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Client: _____

If person is applying for nursing home or HCBS Program equivalent to an alternative to nursing facility care, complete the following level I PASARR Screens during telephone review by PRO.

PASARR/MI/ID/LEVEL I SCREEN

1. Diagnosis of Mental Illness. ( )Yes ( )No
2. Recent (within last two year) history of mental illness or has been prescribed a major tranquilizer or psychotropic medicine on a regular basis in the absence of a justifiable neurological disorder. ( )Yes ( )No

   Prolixen Navane Serentil
   Mellaril Haldol Stelazine
   Thorazine Taractan Lithium
   Loxitane Trilafon
   (or other HCFA approved major tranquilizer)

3. Presenting evidence of mental illness including possible disturbances in orientation, affect or mood (excluding primary diagnosis of Alzheimer's Disease or dementia). ( )Yes ( )No

PASARR/MR/ID/LEVEL I SCREEN

1. Diagnosis of Mental Retardation. ( )Yes ( )No
2. Any history of mental retardation or developmental disability in the individual's past. ( )Yes ( )No
3. Presenting evidence (cognitive or behavior functional) that may indicate the individual has mental retardation or developmental disability. ( )Yes ( )No
4. Referral by an agency that services mentally retarded or developmentally disabled individuals. ( )Yes ( )No

---

Level II Preadmit Exclusions

Does Client Meet:

A. Convalescent Care Criteria? ( )Yes ( )No
B. Severity of Illness Criteria? ( )Yes ( )No
C. Terminal Illness Criteria? ( )Yes ( )No

Level II Preadmit Exclusions:

Does Client meet:

A. Convalescent Care Criteria? ( )Yes ( )No
B. Severity of Illness Criteria? ( )Yes ( )No
C. Terminal Illness Criteria? ( )Yes ( )No

PASARR Comments: . . . . . .

. . . . . .

. . . . . .

_____

Signature of person calling in the ULTC-100

ADDITIONAL INFORMATION:

MEDICATIONS LIST

Medication	Dose	Frequency	Reason	Physician
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				

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MENTAL HEALTH REFERRAL AND SUMMARY FORM
PASARR LEVEL II

I. Client Name:_____ DOB:_____ Sex:____

SSN:_____ Current Placement &/or Address:_____

_____ _____ Legal County of Res.:_____

II. REFERRAL INFORMATION

Date of Referral:_____ CMHC Receiving Referral:_____

Referring Individual/agency/phone#:_____

Type of Referral (check one)

____ PAS (Prior to NF Placement only)

Receiving Facility Name & Prov Number:_____

____ ARR

____ Initial

____ Subsequent

____ Status Change ____ ARR Fast Track

____ Expiration of Exclusion: Type _____

____ Other Exp.:_____

III. PASARR INFORMATION

A. Funding Source:__ Medicaid (#___-___ ___ ___ ___ ___ ___) __Private Pay

B. Type:__Complete __Partial __Checklist __Incomplete Why.:_____

IV. PASARR FINDINGS

A. Level of Care

Client __ DOES __ DOES NOT meet nursing home LOC. As determined by (check one):

__ PRO approval of ULTC-100 (Medicaid only)

__ Other: as per_____

B. Diagnoses (List, with code, primary and secondary dx in each category.)

PSYCHIATRIC: MEDICAL:

_____ _____

_____ _____

_____ _____

C. Mental Health Service Level Required:

1. ____ Emergency Inpatient (27-10)
2. ____ Non-emergency Inpatient
3. ____ Other Mental Health Interventions (See page 2)
4. ____ None
5. ____ N/A - not mentally ill

I have been informed of the above findings. _____

Client/Guardian signature Date

Client Name _____ LTC Facility Name & Number _____

V. MENTAL HEALTH ISSUES IDENTIFIED AND SERVICE RECOMMENDATIONS

Clinical: _____

Medication Management: _____

Case Management: _____

Other (Behavioral) Interventions Recommended: _____

VI. CMHC SERVICE ELIGIBILITY

Medicaid ___ Yes ___ No
Primary MMI as per Current PASARR Findings ___Yes ___ No Dx._____
CMHC Open Client 4/1/89 ____ Yes ____ No
Meets ALL Eligiblity Criteria for CMHC OBRA Services ___Yes ___No
Being Referred for Enhanced OBRA Services ___Yes ___No

VII. OVERALL COMMENTS, CONCERNS, RECOMMENDATIONS: _____

CMHC Signature _____ Date _____ DMH Review _____ Date _____

APPENDIX D-4

FREEDOM OF CHOICE AND FAIR HEARING

1. When a recipient is determined to be likely to require a level of care indicated in item 2 of this request, the recipient or his or her legal representative will be:

   a. informed of any feasible alternatives under the waiver; and

   b. given the choice of either institutional or home and community-based services.

2. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to beneficiaries who are not given the choice of home or community-based services as an alternative to the institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice or the provider(s) of their choice.

3. A copy of the form(s) used to document freedom of choice and to offer a fair hearing is attached to this Appendix. Also attached to this appendix is a description of the agency's procedure(s) for informing eligible recipients (or their legal representatives) of the feasible alternatives available under the waiver and allowing recipients to choose either institutional or home and community-based services, and the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

FREEDOM OF CHOICE DOCUMENTATION

The form used to document recipient freedom of choice between institutional and home and community-based services is attached to this Appendix.

Specify where copies of this form are maintained: In the Case Management Agency records (Client files).

LONG TERM CARE PLAN

Client's Name:

_____

st, First, MI

Medicaid Eligibility:

State ID#_____
___Categoncal
___300%
___QMB

Health Insurance:

___Private Pay
___Private Insurance_____
___Medicare
___HMO_____
___Veterans
___Other _____

Program(s) Authorized by Case Manager:

___HCA
___AFC
___HCBS-EBD
___HCBS-PLWA
___Private Pay CM
___Other_____

Dates Covered by Plan:

_____

From To

Plan Revised:_____
Date

Case Terminated:

_____

Date Reason Code

AREAS OF CONCERN FROM ASSESSMENT (check all that apply)

___Hearing	___Mobility	___Housework	___Access Resources	___Substance Abuse
___Vision	___Dressing	___Laundry	___Telephone	___Mental Health
___Skin Care	___Bathing	___Shopping	___Supervision	___Physical Environment
___Transfers	___Hygiene	___Medicine Mgt	___Cognitive	___Abuse/Neglect
___Bladder Care	___Eating	___Appointments	___Communication	___Transportation
___Bowel Care	___Meal Prep	___Money Mgt	___Housing	___Other_____

Comments:

SERVICE PLAN

SERVICE CATEGORY	Need or Receiving	PROVIDER NAME	FUNDING SOURCE	FREQUENCY	SPECIFIC FUNCTIONS (circle all that apply)
SUPPORTIVE SERVICES					
Adult Protection	N R				
Board & Care	N R		___Private pay ___Public funds	Daily	Room & Board / Oversight
Case Management	N R		___Private Insur.		
Dental Care	N R		___Volunteer ___State OAP ___Private Pay		
Food Stamps	N R	DSS	USDA	Monthly	Aid With Food Purchase
LEAP	N R	DSS	Federal Energy Surtax	December thru April	Aid With Utility Payments
gal Services	N R		___Private ___DSS ___Other		Guardianship Conservatorship Other

SERVICE PLAN					
SERVICE CATEGORY	Need or Receiving	PROVIDER NAME	FUNDING SOURCE	FREQUENCY	SPECIFIC FUNCTIONS (circle all that apply)
Meals	N R		___Title III ___Private Pay		Congregate / Home Delivered
Mental Health Counseling	N R		___Medicaid ___Public funds ___Private Pay ___Private Insur.		
Money Management	N R		___Private		Assistance, Representative Payee
Rehab Services	N R		___Voc. Rehab. ___Private		Training, Education, Job Placement, Other:
Senior Companion	N R		___Title III ___Private		
Subsidized Housing	N R		HUD, FAH, FMHA	Monthly	Rent Supplement
Other Services	N R				
STATE PLAN BENEFITS					
Home Health	N R		___Medicare ___Medicaid ___Private Pay ___Other_____	Nurse:_____ Aide:_____ PT:_____ OT:_____ ST:_____	Skilled Care Specify:
Home Health (2nd Funding Source)	N R		___Medicare ___Medicaid ___Private Pay ___Other_____	Nurse:_____ Aide:_____ PT:_____ OT:_____ ST:_____	Skilled Care Specify:
Hospice	N R		___Medicare ___Medicaid ___Private Pay ___Other:	Daily	Palliative Care
Medical Equipment	N R		___Medicare ___Medicaid ___Private Pay		Chair, Walker, Bed, IV Equipment, Bath Adaptations, Room, Other:
Other Services	N R				

SERVICE PLAN

SERVICE CATEGORY	Need or Receiving	PROVIDER NAME	FUNDING SOURCE	FREQUENCY	SPECIFIC FUNCTIONS (circle all that apply)
SINGLE ENTRY POINT LONG TERM CARE SERVICES					
Adult Day Care	N R		___HCBS ___Private Pay ___Other:	___Days/week ___Half-days/ week	___Maintenance ___Restorative: Nsg / PT / OT / ST
Assisted Living	N R		___AFC ___HCBS/EBD (ACF) ___Private Pay ___Other:	Daily	Personal Care / Homemaker / Protective Oversight / Room and Board
Electronic Monitoring	N R		___HCBS ___Private Pay ___Other:	___Monthly ___One Time Only	Lifeline / Call System / Other:
Homemaker	N R	___Relative ___Spouse ___Non-Relative ___Agency Name:	___HCBS ___HCA ___Title III ___Private Pay ___Other:	___Visits per week ___Hours per visit	Cleaning / Shop / Linen Change / Meal Prep / Laundry / Transp / Other:
Homemaker (2nd Funding Source)	N R	___Relative ___Spouse ___Non-Relative ___Agency Name:	___HCBS ___HCA ___Title III ___Private Pay ___Other:	___Visits per week ___Hours per visit	Cleaning / Shop / Linen Change / Meal Prep / Laundry / Transp / Other:
Home Modification	N R		___HCBS ___Private Pay ___Other:	One Time Only	Grab Bars / Tub Seat / Hand Held Shower / Rails / Wheelchair Ramp / Other:
Medical Transportation	N R		___Medicaid ___HCA ___Title III ___Private Pay		
Non-Medical Transportation	N R	___Relative ___Spouse ___Non-Relative ___Agency Name:	___HCBS ___HCA ___Private Pay ___Other:	___1-way trips/ week ___Miles/1-way trip	To: ADC / Shopping / Errands / Sheltered Workshop / Other:

SERVICE PLAN

SERVICE CATEGORY	Need or Receiving	PROVIDER NAME	FUNDING SOURCE	FREQUENCY	SPECIFIC FUNCTIONS (circle all that apply)
Non-Medical Transportation (2nd Funding Source)	N R	___Relative ___Spouse ___Non-Relative ___Agency Name:	___HCBS ___HCA ___Private Pay ___Other:	___1-way trips/ week ___Miles/1-way trip	To: ADC / Shopping / Errands / Sheltered Workshop / Other:
Nursing Care Facility	N R		___Medicare ___Medicaid ___Private Pay ___Other:	Daily	Skilled and Maintenance Care
Personal Care	N R	___Relative ___Spouse ___Non-Relative ___Agency Name:	___HCBS ___HCA ___Title III ___Private Pay ___Other:	___Visits per week ___Hours per visit	Bathing / Exercise / Transfer / Ambulation / Hair / Skin Care / Dressing / Toileting / Feeding / Homemaker Duties / Other:
Personal Care (2nd Funding Source)	N R	___Relative ___Spouse ___Non-Relative ___Agency Name:	___HCBS ___HCA ___Title III ___Private Pay ___Other:	___Visits per week ___Hours per visit	Bathing / Exercise / Transfer / Ambulation / Hair / Skin Care / Dressing / Toileting / Feeding / Homemaker Duties / Other:
Personal Care (3rd Funding Source)	N R	___Relative ___Spouse ___Non-Relative ___Agency Name:	___HCBS ___HCA ___Title III ___Private Pay ___Other:	___Visits per week ___Hours per visit	Bathing / Exercise / Transfer / Ambulation / Hair / Skin Care / Dressing / Toileting / Feeding / Homemaker Duties / Other:
Private Duty Nursing	N R		___Medicaid ___HCBS-PLWA ___Private Pay ___Other:	___Visits per week ___Hours per visit	RN / LPN / Nursing Assessment
Program for All-Inclusive Care (TLC)	N R		___Medicare ___Medicaid ___Private Pay ___Other:	ADC:	Case Management / Adult Day Care / Other:
Respite Care	N R	___Relative ___Spouse ___Non-Relative ___Agency Name:	___HCBS ___HCA ___Private Pay ___Other:	From: Thru:	NF / Hospital / Boarding Home / ACF / AFC / ADC / Personal Care In Home / Other:

SERVICE PLAN

SERVICE CATEGORY	Need or Receiving	PROVIDER NAME	FUNDING SOURCE	FREQUENCY	SPECIFIC FUNCTIONS (circle all that apply)
_4-Hour Personal Care	N R	___Relative ___Spouse ___Non-Relative ___Agency Name:	___HCA ___Private Pay ___Other:	Daily Effective Date:	Bathing / Exercise / Transfer / Ambulation / Hair / Skin Care / Dressing / Toileting / Feeding / Homemaker Duties / Other:
Other Services	N R				

I HAVE BEEN INFORMED OF THE CHOICE OF PROVIDERS AVAILABLE AND UNDERSTAND I MAY CHANGE PROVIDERS AT ANY TIME I WILL NOTIFY MY CASE MANAGER WHEN I CHANGE PROVIDERS. I HAVE REVIEWED THE SERVICES CONTAINED IN THIS CARE PLAN AND CHOOSE TO ACCEPT THESE SERVICES OFFERED IN:

____ Community ____ Nursing Facility

_____ _____

Signature of Client Date

_____ _____

_ ıature of Case Manager Date

___Plan Revision (no client signature required)

SUMMARY OF PLAN REVISIONS		
DATE	REASON	EXPLANATION
	___Medical ___Functional ___Residential ___Psychosocial ___Other:	
	___Medical ___Functional ___Residential ___Psychosocial ___Other:	

DATE	UNMET NEEDS	CRITICAL NEED?	REASON NEED NOT MET

COMMENT SECTION:

INSTRUCTIONS FOR THE LONG TERM CARE PLAN

This form is used by the Single Entry Point agency case manager to develop a service plan for the client. This Long Term Care Plan replaces the 103/104 previously used by the HCBS-EBD program. It also replaces the 403/404 used by the HCBS-PLWA program and the SS-6 used by the Home Care Allowance program.

In this Long Term Care Plan, the case manager checks the areas of concern regarding the client's functioning which were identified through the assessment process. In turn, the corresponding services which the client needs in order to function more effectively are noted. For each service needed, the case manager documents the provider of the service, the funding source, the frequency at which the service is needed and the specific functions of the service which the client needs.

Following the completion of the Plan, the client signs the form to document his/her participation in the planning process.

IDENTIFYING INFORMATION:

The first section of page 1 of the form asks for **identifying information** about the client and the care plan. In the upper left hand corner of the top of the page, record the client's name and a series of identifying numbers—the client's state ID (Medicaid #) number, the number of the county of residence and the number of the Single Entry Point (SEP) agency which is processing the Plan.

Medicaid eligibility status: Check the client's Medicaid eligibility status including whether or not the client is categorically eligible to receive Medicaid or is in the 300% category. If you are not sure which of these categories applies, check with the eligibility technician in the County Department of Social Services. The QMB status refers to whether or not the person is eligible as a Qualified Medicare Beneficiary. If it appears that the client will use private resources to pay for services, check this category.

Programs authorized: Check all of the programs which the client is authorized to receive services from. This list of programs includes the publicly funded long term care programs, (HCA, AFC, HCBS-EBD, HCBS-PLWA), the long term care programs funded by regular Medicaid (Home Health, Hospice) and the private pay component of the SEP agency.

Dates covered by the Plan: Enter the dates covered by the Plan from the beginning of the Plan to the end date, using the month/date/year format, two digits for each, e.g. 07-01-91. These dates must correspond with the program requirements if the person is receiving services from the

HCBS-EBD or HCBS-EBD programs. You will need to check the program rules for this information. If the Plan being completed is a revised Plan, check this category and the date of the revision.

Termination: If the case is being terminated, fill in the date and select from the following codes the reason for the termination.

01--Client no longer financially eligible
02--Client no longer programmatically eligible
03--Nursing facility resident for more than 30 days
04--Client moved out of state
05--Client transferred out of the SEP
06--Client preference to terminate services
07--Client died
08--Other (specify)

AREAS OF CONCERN FROM THE ASSESSMENT:

This section of the Plan requires that you check all of the responses that apply to the client. This is information about the client's functional problems identified through the assessment process which you will use in developing the service plan. Space has been provided for your comments regarding the client's problems.

SERVICE PLAN:

This section of the Plan identifies the services needed by the client and provides information about each of the services which you have identified as needed by the client. The list of services is divided into three categories: 1) Supportive services; 2) Services which are part of the Medicaid state plan benefits; and 3) Single entry point long term care services. In planning for the client's care, keep in mind that you should always consider the most cost effective plan for the individual, selecting those services and providers which can be provided at no cost from family, friends, neighbors and volunteers and then proceeding to the appropriate public programs.

First, select the service(s) needed by the client in each category. Select only those you have identified as needed by the client. For each service, there are five headings or categories of information which you need to fill out for each service selected. Complete this information by going across the form. These headings include:

1. Need or receiving: Circle "R" if the client is currently receving the service; circle "N" if the client needs the service and is currently not receiving it.

2. **Provider name:** Check the appropriate response and write in the name of the provider of the service. Note that this category includes the range of possible providers, including relatives, spouse, non-relative providers and agencies.

3. **Funding source:** If the funding source for the service is known, check the program or funding source which will be used to pay for the service. Responses in this category include the publicly funded long term care programs under the SEP agency, Medicare, specialized public funds (e.g. USDA for food stamps) and private resources, including private insurance.

4. **Frequency:** This category refers to how often the client needs the service. Check the appropriate response. In cases where the service is provided consistently in the same frequency (i.e. food stamps are always provided monthly), the response has been written in. If this response is not correct for your client, write in the correct response. Note that the responses vary depending on the type of service.

5. **Specific functions:** Some of the services have several different functions and clients may need only certain services provided under a broader category; for example, homemaker services include cleaning, meal prep, laundry, etc. Circle all the responses that apply here or write in the response, if appropriate.

SERVICE CATEGORIES:

The following information defines each of the services listed in the Plan. Complete only the parts of this section that are applicable to a particular client; do not complete the sections that are not applicable. The form has been designed to minimize unnecessary repetitive writing by the user of the form, in that some responses have been written in.

Section 1: Supportive Services. This list of services should be considered first in planning for the client's care. They are services which a person might receive from a variety of programs and funding sources outside the long term care programs offered by the SEP publicly funded programs. These services should be considered as supportive in that they can offer the client a living environment which enhances their functioning. For convenience sake, the services have been alphabetized.

Adult Protection: Persons whom you suspect as being "at risk of mistreatment or self-neglect should be referred to Adult Protection at the County Department of Social Services where they reside. An "at risk" adult is defined as an individual age 18+ who is susceptible to mistreatment or self-neglect because he/she is unable to perform or obtain services necessary for their health and safety or lacks sufficient understanding or capacity to make responsible decisions concerning their welfare or affairs. Abuse can include physical pain or injury, nonconsensual sexual conduct, caretaker neglect and financial exploitation. Self-neglect occurs when a person acts or fails to act and endangers

their health, safety, welfare or life by not seeking the necessary services. For more information on adult protection, see Appendix .

Board and Care: Board and care facilities provide room and board and varying levels of protective oversight and supervision for three or more unrelated persons. If the client is in a facility identified as a board and care home, enter the name of the board and care home under "Provider Name". Check the appropriate funding source for the client's care in the facility. Circle all services that the client receives from the facility operator.

Case Management: Although case management is provided through the SEP as part of the administration of the publicly funded long term care programs, private pay clients may need and request case management. Case management usually includes assessment, case planning, service brokering, monitoring and follow-up. However, the model used may vary according to the individual's needs. Write in the provider of case management, the funding source, frequency of need and functions needed.

Dental Care: Dental care can be made available through volunteer dental programs, private pay and the state OAP dental program. Complete the other categories of information for dental care.

Food Stamps: If the client receives or needs Food Stamps, circle this response. You will note that the other responses have been completed for you.

LEAP: If the client needs or is receiving LEAP (Low Income Energy Assistance Program), provided through the County Department of Social Services, simply circle "N" or "R". All other columns for this service have been pre-printed.

Legal Services: Clients may need legal advice or protection in the form of guardianship or conservatorship. Enter the name of the provider and the frequency at which the service is needed. Circle the correct funding source and the functions required.

Meals: Persons who need assistance with meals can have them provided in a congregate setting or at their place of residence. Write the name of the provider under "Provider Name" (e.g. "Brighton Senior Center" or "VOA"). The "Funding Source" column is pre-printed. In the "Frequency" column, specify how often meals are provided. In the Specific Functions section, check the type or location of the delivered meals, whether in a congregate setting or in the client's home.

Mental Health Counseling: Under "Provider Name", list the name of the center or other mental health provider from which the client is receiving mental health services. The "Funding Source" is pre-printed. Under "Frequency", specify how often the client receives services. Under "Specific Functions", list the exact services, (e.g. "grief counseling" or "prolixin injections").

Money Management: Persons may need help managing their money and paying their bills as well as a representative payee to pay their bills. Write in the provider and frequency and check the funding source.

Rehabilitative Services: These services are usually related to work training and preparation. Write in the provider name and the frequencey. Circle the functions which the client need.

Senior Companion: This Federally funded program can provide an older person with an opportunity to earn a stipend by providing assistance in the home to persons in need. In addition, a client might benefit from the services provided by the Senior Companion. Write in the name of the agency providing the program and specify the frequency and functions needed.

Subsidized Housing: A federally funded program which provides rent supplements to persons at lower income levels. Identify the housing facility. The other responses have been completed.

Other Services: This category includes any services not specifically listed above (e.g. VA Aid and Attendant or Title-III funded transportation). Before listing any other services, check the list included on this form to be sure they are not included in any of the other categories. Write the name of the person or agency providing the service under the heading, "Provider Name". Under "Funding Source", specify the source of the funding. Under "Frequency", state how often the client receives the service. Specify the exact nature of the services under "Specific Functions".

Section 2: State Plan Benefits. The following list of services are provided as part of the Medicaid State Plan as both mandated benefits and optional services. You should note, however, that these services can also be purchased through other funding sources, such as from private resources and Medicare.

Please note that home health is listed twice. It is conceivable that an individual could receive home health care from more than one funding source. Use a separate box to identify home health funded by different sources.

Home Health: An assessment on an individual may indicate a need for skilled services offered in the home. If so, it is advisable to have a home health agency assess the need for skilled services. Home Health Aide services can be provided only if skilled personal care is being provided which requires the instruction and direct supervision of a nurse or therapist. Note, that when Home Health services are included in the case plan for Medicaid funded Home Health, the case manager must obtain and file in the case record, a copy of each 60-day Home Health Plan of care. When therapy services are provided, separate plans of care must be furnished by the home health agency.

(All rules and regulations of the Medicaid Home Health program apply to skilled home health services when such services are part of the case plan for HCBS clients).

For Home Health care, identify the provider by the name of the agency, check the appropriate responses for the funding source; check the frequency at which the service is needed by the type of provider, and, write in the specific function required.

Hospice: This program offers palliative and supportive medical services for terminally ill persons. It is offered in the home and in a variety of in-patient settings. Identify the provider and check the funding source.

Medical Equipment: Check if the client needs or is receiving durable medical equipment during this plan period. Write the name of the agency or company providing the equipment under the column, "Provider Name". The "Funding Source" is pre-printed. Under "Frequency", state how often the equipment will be provided. In most cases, this will be "1 X only". Under "Specific Functions", identify the equipment and its purpose.

Other Services: If the client receives any other services, please list them and fill in the other categories of information.

Section 3: Single Entry Point Long Term Care Services. This list of services is available through the long term care programs administrated by the SEP agencies. For the private pay client, many of these services are also available on a fee-for-service basis. There are a number of services which are listed more than once, including homemaker services, non-medical transportation, and personal care. As with services listed more than once in the other categories, this enables you to provide information about a service when it is provided by different programs or funding sources.

Adult Day Care: Health and social services provided on a less than 24 hour basis in state certified facilities. Enter the Adult Day Care provider's name and check the payment source, the frequency at which the client will attend the facility and the functions required.

For "Specific Functions", there are two choices: "Maintenance Model" or "Restorative Model". This refers to the two different types of Day Care facilities that may be certified in Colorado. Most centers are maintenance centers (see 8.491.12a and 8.491.13). If the client is attending a restorative day care center, the center is required to provide daily nursing, physical therapy, occupational therapy and speech therapy, in addition to all the services provided at a maintenance center (see 8.491.12b and 8.491.14). Indicate which of these services the client is receiving from the restorative model day care center by circling all those which apply. You will not circle any of these services if the day care center is a maintenance model.

Assisted Living: Social, supportive and supervisory services provided in a congregate living situation. Enter the name of the facility provider, check the funding source and circle the services which the facility needs to provide for the client.

The Medicaid assisted living program is the Alternative Care Facility program.

Electronic Monitoring: This is electronic equipment or adaptations which enhance the living environment for an individual. Identify the provider of the equipment and check the funding source and frequency responses. The functional section should describe the specific kind of equipment required.

Homemaker: This service includes general household tasks provided by certified agencies to maintain a safe and healthy environment for the client. Some individuals will be receiving homemaker services from different sources and paid for by different programs. Complete both boxes if this situation is applicable for your client. List the provider(s), check the funding source, required visits and the specific functions to be performed for the client.

Home Modification: This service includes home installations or adaptations which are related to the client's physical impairment and which enable the person to remain at home. Enter the name of the provider and check or circle the other responses.

Medical Transportation: The provision of transportation of persons to receive medical care. Identify the provider, check the funding source and write in the frequency at which the transportation is needed and any specific functions.

Non-Medical Transportation: The transportation of persons to services, such as adult day care, which enable the person to remain at home. There are two boxes for a person receiving this transportation from multiple funding sources.

Nursing Facility Care: A facility which provides 24-hour skilled nursing and maintainence care. A client may need to temporarily enter a nursing facility if a medical condition warrants it or enter on a more long term basis when their condition deteriorates. Name the nursing facility and check the funding source.

Personal Care: Services to assist a person with physical limitations and functional needs when the services do not require the supervision of a nurse. There are three boxes so you can identity personal care provided by different programs and funding sources. Check the type of provider (relative, spouse, non-relative or agency) and list the name of the provider. Check the appropriate funding source, the frequency at which the service is needed and the specific tasks required under the function section.

Private Duty Nursing: Skilled nursing visits provided in the home. For the publicly funded long term care clients, this service is available for only HCBS-PLWA clients. Identify the provider and check the payment source and the frequency needed. Circle the specific functions required.

Program for All Inclusive Care (TLC): A comprehensive program of services, including case management and adult day care, provided to frail, elderly persons in the Denver area, operated by Total Long Term Care, Inc. Insert the provider name and check the funding source for your client and the functions needed.

Respite Care: Short-term services for a client to relieve the caregivers from the care and maintenance of the client. Check the kind of provider and list the name. Check the funding source and circle the place where the care is to be provided. Identify the time frame for the provision of the care.

Twenty-Four Hour Personal Care: Personal care provided on a 24-hour basis in the home or a facility. This service is only available for Home Care Allowance clients. Check the provider type and list the name of the provider, the funding source and enter the frequency. Circle the specific functions needed.

Other Services: List any other services which the client may need and complete the necessary information for the service identified.

SIGNATURE SECTION: The last section of the Plan includes a section which the client and the case manager sign. Be sure to have the client read the statement or read it to him/her before signing. The date needs to be included. At the end of the form is a statement which needs to be checked if this Plan is a revision.

If this is a Plan revision, complete the attached page which has two sections: **SUMMARY OF PLAN REVISIONS** and **UNMET NEEDS**. The revision section includes a section on the reason for the revision and an explanation for this. The unmet need section gives you an opportunity to identify any of the client's needs which have not been met, whether these were critical to their health or safety and the reason the needs were not able to be met.

NOTICE OF SERVICE STATUS/ELIGIBILITY

Home and Community Based Services

Si no puedes comprender esta noticia, por favor llama al "case manager"
El numero del telefono es _____

Client's Name _____ Medicaid I.D. # _____

Address _____ Phone # _____

A. ☐ You are eligible to receive Home And Community Based Services. No action is required by you.

B. ☐ You are not eligible/no longer eligible to receive Home and Community Based Services because you are not Medicaid eligible.

YOU WILL ALSO BE NOTIFIED OF THIS ACTION BY YOUR COUNTY DEPARTMENT OF SOCIAL SERVICES. THEY WILL EXPLAIN YOUR APPEAL RIGHTS.

C. You are not eligible/no longer eligible to receive Home and Community Based Services for the following reasons:

☐ You do not require nursing home/HCBS level of care, as determined by PRO.

☐ You do not meet LTC target group definition for HCB-EBD, as assigned by PRO.

YOU WILL ALSO BE NOTIFIED OF THIS ACTION BY THE COLORADO FOUNDATION FOR MEDICAL CARE. THEY WILL EXPLAIN YOUR APPEAL RIGHTS.

D. ☐ Client payment is past due. You owe $ _____ for the month(s) of _____

☐ Home and Community Based Services are being decreased effective _____ because: _____

_____

Services being decreased are: _____

☐ You are not eligible/no longer eligible to receive HCB Services effective _____ for the following reasons:

- ☐ Service costs exceed the maximum allowable expenditure.
- ☐ You are living in a congregate setting that is out of compliance with Personal Care Boarding Home Regulations.
- ☐ Home and Community Based Services are not appropriate/no longer appropriate because:

_____

_____

RULE(S) WHICH APPLY: _____

If you disagree with the proposed action described in part D. above and want to appeal, i.e., have a Case Management Agency hearing you must

CALL YOUR CASE MANAGER BEFORE THE EFFECTIVE DATE SHOWN ABOVE

For explanation of your rights to appeal the action checked on part D. above, please see other side of this form.

Case Management Agency _____ Address _____

_____ _____ _____ _____

Case Manager's Signature | Phone Number | Signature of Immediate Supervisor | Phone Number

I certify that I have mailed this form as above completed to the above-named individual by deposit of the same in the U.S. Mail, postage prepaid, on the date shown.

_____ _____

Signature of Person Responsible for placing Notice in Mail | Date Placed in the U.S. Mail

LTC-107 (Revised 8/89)
394-30-46-1077

White Copy to Client
Yellow Copy to Case Record

D. EXPLANATION OF PRIOR NOTICE PROCEDURE, APPEAL PROCESS AND RIGHTS

The following is an explanation of the notice appearing in **PART D**, on the other side of this form, the procedure which it initiates, and your rights of appeal. Generally, you are given two chances to appeal. One to the Case Management Agency, and/or a second level to the State. The Case Management Agency can not make the change they tell you about until the end of the prior notice period.

1. PRIOR NOTICE: When your Case Management Agency determines that it must deny an application for services or take an action which adversely affects you, the Case Management Agency is required to provide an advance notice of such intended action to you at least 10 days before the date that it would become effective (which is "the prior notice period"). The notice must tell you what the Case Management Agency intends to do, why the action appears necessary, and the Case Management Agency rule, or rules, which appear to be applicable, and on which the intended action is based. This gives you time to receive the mailed notice, get further explanation from the Case Management Agency (or give them additional information), to decide whether to go for the Case Management Agency hearing, and, if so, to prepare for that hearing.

2. CASE MANAGEMENT AGENCY EVIDENTIARY HEARING: After you get the prior notice, and if you disagree with the intended action and want to appeal,

YOU MUST CALL YOUR CASE MANAGER TO SAY THAT YOU WANT TO APPEAL. THIS CONTACT WITH THE CASE MANAGER MUST BE MADE WITHIN THE 10-DAY PRIOR NOTICE PERIOD.

If you do not come to the Case Management Agency hearing on the appointed day or get an extension, the conclusion is made that only hearing right is given up and the Case Management Agency will carry out its intended action. In an extreme emergency, a further delay may be granted. The Case Management Agency hearing is conducted by an individual who is not involved in your case and is required to be impartial. That person will make the decision as to whether the Case Management Agency intended action is right or wrong. If it is determined to be wrong, the action intended will not be carried out. If the intended action is determined by the Case Management Agency hearing officer to be correct, the action will be carried out. If you still disagree, you then can go to the next step which is to the State in appeal.

3. STATE APPEALS: If you disagree with the Case Management Agency action explained on the other side of this form and decide that you will not ask for a Case Management Hearing, you can still appeal to the State Department of Social Services. However, you must start that appeal (get your request in the mail to the State) not later than 26 days from the mailing date shown on the other side of this form.

If you have had a Case Management Agency hearing and you still disagree with the action which they took in your situation, you can appeal to the State Department of Social Services. If you want to do this, you must get your request in the mail **NOT LATER THAN 15 DAYS AFTER THE CASE MANAGEMENT AGENCY HEARING DECISION** with which you disagree. You also have the right to appeal to the State Department of Social Services if the Case Management Agency (1) did not act quickly enough on your request for help (an application for services) or (2) took too long to provide services, or (3) took an action which you think wrongs you and which involved interpretation of the law or the rules as applied in your particular situation, or (4) took some action with which you disagree in redetermining your eligibility for services or the amount of services. When you want to appeal something which is not covered in the notice process, you must start that appeal (get your request in the mail) not later than 15 days from the date the improper action took place. The Case Management Agency is required to give you full and complete explanations of actions it takes and how it computes the benefits provided, so it is suggested that you get a full understanding from them as to what the action is before you file an appeal. However, the right to appeal is yours in any case. If you want to start a State appeal, you should write a letter to:

Division of Administrative Hearings, 1525 Sherman Street, Room 550, Denver, CO 80203.

Say in the letter that you want to appeal and why. If you need help to do this, you can ask anyone you desire to help you, or talk to a Legal Aid Office, or ask your Case Manager to help you. When such an appeal is received, you will get a letter from them explaining what will be done and the date, etc., for the appeal hearing. They will also tell you about who can come with you, present testimony, and other details about an appeal hearing. You should be aware that the State and Case Management Agency are required to attempt collection or get repayment of all benefits provided you for which you were not entitled.

4. INTERIM RELIEF: At any time during the appeal process concerning a reduction or termination of benefits, you may request interim relief, i.e., that the action described upon the other side of this form be postponed until the appeal process is completed. If it can be shown that irreparable damage will occur if the action is completed, interim relief will be granted. Requests for interim relief should be directed to the Office of Appeals at the address given above.

5. JUDICIAL REVIEW: If you disagree with the decision from the State appeal, you have the right to apply for judicial review in the appropriate State District Court. Such requests for judicial review must be filed in accordance with the rules of civil procedure for courts of record in Colorado and must be filed within thirty days after the appeal decision becomes effective.

6. DISCRIMINATION: If you believe that you have been discriminated against because of race, color, sex, age, religion, political beliefs, national origin, or handicap, you have the right to file a complaint with the Colorado Civil Rights Division, 1525 Sherman Street, Denver, Colorado 80203, or the Secretary of Human Services, 330 Independence Avenue, S.W., Washington, D.C. 20201.

APPENDIX E-1

PLAN OF CARE DEVELOPMENT

a. Specify the minimum qualifications of the individuals responsible for the preparation of the plans of care.

The minimum qualifications for a case manager are:
1. A masters degree in the human behavioral sciences; or
2. A Bachelor of Social Work degree accredited by the Council on Social Work Education; or
3. A Bachelor degree in one of the human behavioral sciences plus one year professional casework experience.
For the purposes of training and substitution on experience for education, exceptions may be made as approved by the State and/or allowed by Colorado Department of Social Services Staff Manual Volume II - County Personnel and Merit System.

b. The following is a description of the process by which the initial plan of care is developed for deinstitutionalized individuals.

The case manager assesses the client's diagnostic information, level of functioning, service needs and preferences; and evaluates the available resources and potential funding sources. With input from the client and others, the case manager writes a case plan which describes all service to be provided, including the funding source, frequency, amount and type of each service. The client signs the case plan, agreeing to accept the services instead of nursing facility services.

c. The following is a description of the process by which the initial plan of care is developed for diverted individuals.

Same as b above.

d. The following is a description of the process by which ongoing plans of care are developed for individuals served on the waiver.

Same as b above.

e. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify the location(s) where copies of the plans of care will be maintained.

Client records at the Case Management Agency.

f. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the recipients. The following is a description of the process by which the State will ensure that plans of care are reviewed at designated intervals. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure what the services furnished are consistent with the nature and severity of the recipient's disability. Attached is an indication of the minimum schedule under which these reviews will occur.

The case plans will be reviewed as follows:

1. At development of initial plan, and
2. At time of continued stay review, at least annually, and
3. As required whenever services must be added or increased.

APPENDIX E-2

MEDICAID AGENCY APPROVAL

a. The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

The State contracts with Blue Cross who will provide 100% prior authorization of services.

Unusual request will be submitted to the Division of Mental Health for approval.

The Division of Mental Health will do regular quality assurance reviews of approved Plans of Care.

b. Specify the qualifications of the person within the Medicaid agency who is responsible for plan of care approval.

At Blue Cross, Registered Nurses

At the Division of Mental Health, MSW or PHd with consultation with RNs for nursing related issues.

STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

a. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, frequency and duration of each service, and the type of provider to furnish each service.

b. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

LONG TERM CARE PLAN

Client's Name: _____ st, First, MI	Program(s) Authorized by Case Manager:	Dates Covered by Plan: _____ From To
Medicaid Eligibility: State ID# _____ ___Categoncal ___300% ___QMB	**Health Insurance:** ___Private Pay ___Private Insurance _____ ___Medicare ___HMO _____ ___Veterans ___Other: _____	___HCA ___AFC ___HCBS-EBD ___HCBS-PLWA ___Private Pay CM ___Other _____	Plan Revised: _____ Date **Case Terminated:** _____ Date Reason Code

AREAS OF CONCERN FROM ASSESSMENT (check all that apply)

___Hearing ___Vision ___Skin Care ___Transfers ___Bladder Care ___Bowel Care	___Mobility ___Dressing ___Bathing ___Hygiene ___Eating ___Meal Prep	___Housework ___Laundry ___Shopping ___Medicine Mgt ___Appointments ___Money Mgt	___Access Resources ___Telephone ___Supervision ___Cognitive ___Communication ___Housing	___Substance Abuse ___Mental Health ___Physical Environment ___Abuse/Neglect ___Transportation ___Other _____

Comments:

SERVICE PLAN

SERVICE CATEGORY	Need or Receiving	PROVIDER NAME	FUNDING SOURCE	FREQUENCY	SPECIFIC FUNCTIONS (circle all that apply)
SUPPORTIVE SERVICES					
Adult Protection	N R				
Board & Care	N R		___Private pay ___Public funds	Daily	Room & Board / Oversight
Case Management	N R		___Private Insur.		
Dental Care	N R		___Volunteer ___State OAP ___Private Pay		
Food Stamps	N R	DSS	USDA	Monthly	Aid With Food Purchase
LEAP	N R	DSS	Federal Energy Surtax	December thru Apnl	Aid With Utility Payments
gal Services	N R		___Private ___DSS ___Other		Guardianship Conservatorship Other

SERVICE PLAN

SERVICE CATEGORY	Need or Receiving	PROVIDER NAME	FUNDING SOURCE	FREQUENCY	SPECIFIC FUNCTIONS (circle all that apply)
Meals	N R		___Title III ___Private Pay		Congregate / Home Delivered
Mental Health Counseling	N R		___Medicaid ___Public funds ___Private Pay ___Private Insur.		
Money Management	N R		___Private		Assistance, Representative Payee
Rehab Services	N R		___Voc. Rehab. ___Private		Training, Education, Job Placement, Other
Senior Companion	N R		___Title III ___Private		
Subsidized Housing	N R		HUD, FAH, FMHA	Monthly	Rent Supplement
Other Services	N R				
STATE PLAN BENEFITS					
Home Health	N R		___Medicare ___Medicaid ___Private Pay ___Other_____	Nurse:_____ Aide:_____ PT:_____ OT:_____ ST:_____	Skilled Care Specify:
Home Health (2nd Funding Source)	N R		___Medicare ___Medicaid ___Private Pay ___Other_____	Nurse:_____ Aide:_____ PT:_____ OT:_____ ST:_____	Skilled Care Specify:
Hospice	N R		___Medicare ___Medicaid ___Private Pay ___Other:	Daily	Palliative Care
Medical Equipment	N R		___Medicare ___Medicaid ___Private Pay		Chair, Walker, Bed, IV Equipment, Bath Adaptations, Room, Other:
Other Services	N R				

SERVICE PLAN

SERVICE CATEGORY	Need or Receiving	PROVIDER NAME	FUNDING SOURCE	FREQUENCY	SPECIFIC FUNCTIONS (circle all that apply)
SINGLE ENTRY POINT LONG TERM CARE SERVICES					
Adult Day Care	N R		___HCBS ___Private Pay ___Other:	___Days/week ___Half-days/ week	___Maintenance ___Restorative: Nsg / PT / OT / ST
Assisted Living	N R		___AFC ___HCBS/EBD (ACF) ___Private Pay ___Other:	Daily	Personal Care / Homemaker / Protective Oversight / Room and Board
Electronic Monitoring	N R		___HCBS ___Private Pay ___Other:	___Monthly ___One Time Only	Lifeline / Call System / Other:
Homemaker	N R	___Relative ___Spouse ___Non-Relative ___Agency Name:	___HCBS ___HCA ___Title III ___Private Pay ___Other:	___Visits per week ___Hours per visit	Cleaning / Shop / Linen Change / Meal Prep / Laundry / Transp / Other:
Homemaker (2nd Funding Source)	N R	___Relative ___Spouse ___Non-Relative ___Agency Name:	___HCBS ___HCA ___Title III ___Private Pay ___Other:	___Visits per week ___Hours per visit	Cleaning / Shop / Linen Change / Meal Prep / Laundry / Transp / Other:
Home Modification	N R		___HCBS ___Private Pay ___Other:	One Time Only	Grab Bars / Tub Seat / Hand Held Shower / Rails / Wheelchair Ramp / Other:
Medical Transportation	N R		___Medicaid ___HCA ___Title III ___Private Pay		
Non-Medical Transportation	N R	___Relative ___Spouse ___Non-Relative ___Agency Name:	___HCBS ___HCA ___Private Pay ___Other:	___1-way trips/ week ___Miles/1-way trip	To: ADC / Shopping / Errands / Sheltered Workshop / Other:

SERVICE PLAN

SERVICE CATEGORY	Need or Receiving	PROVIDER NAME	FUNDING SOURCE	FREQUENCY	SPECIFIC FUNCTIONS (circle all that apply)
Non-Medical Transportation (2nd Funding Source)	N R	___Relative ___Spouse ___Non-Relative ___Agency Name:	___HCBS ___HCA ___Private Pay ___Other:	___1-way trips/ week ___Miles/1-way trip	To: ADC / Shopping / Errands / Sheltered Workshop / Other:
Nursing Care Facility	N R		___Medicare ___Medicaid ___Private Pay ___Other:	Daily	Skilled and Maintenance Care
Personal Care	N R	___Relative ___Spouse ___Non-Relative ___Agency Name:	___HCBS ___HCA ___Title III ___Private Pay ___Other:	___Visits per week ___Hours per visit	Bathing / Exercise / Transfer / Ambulation / Hair / Skin Care / Dressing / Toileting / Feeding / Homemaker Duties / Other:
Personal Care (2nd Funding Source)	N R	___Relative ___Spouse ___Non-Relative ___Agency Name:	___HCBS ___HCA ___Title III ___Private Pay ___Other:	___Visits per week ___Hours per visit	Bathing / Exercise / Transfer / Ambulation / Hair / Skin Care / Dressing / Toileting / Feeding / Homemaker Duties / Other:
Personal Care (3rd Funding Source)	N R	___Relative ___Spouse ___Non-Relative ___Agency Name:	___HCBS ___HCA ___Title III ___Private Pay ___Other:	___Visits per week ___Hours per visit	Bathing / Exercise / Transfer / Ambulation / Hair / Skin Care / Dressing / Toileting / Feeding / Homemaker Duties / Other:
Private Duty Nursing	N R		___Medicaid ___HCBS-PLWA ___Private Pay ___Other:	___Visits per week ___Hours per visit	RN / LPN / Nursing Assessment
Program for All-Inclusive Care (TLC)	N R		___Medicare ___Medicaid ___Private Pay ___Other:	ADC:	Case Management / Adult Day Care / Other:
Respite Care	N R	___Relative ___Spouse ___Non-Relative ___Agency Name:	___HCBS ___HCA ___Private Pay ___Other:	From: Thru:	NF / Hospital / Boarding Home / ACF / AFC / ADC / Personal Care In Home / Other:

SERVICE PLAN

SERVICE CATEGORY	Need or Receiving	PROVIDER NAME	FUNDING SOURCE	FREQUENCY	SPECIFIC FUNCTIONS (circle all that apply)
_4-Hour Personal Care	N R	___Relative ___Spouse ___Non-Relative ___Agency Name:	___HCA ___Private Pay ___Other:	Daily Effective Date:	Bathing / Exercise / Transfer / Ambulation / Hair / Skin Care / Dressing / Toileting / Feeding / Homemaker Duties / Other:
Other Services	N R				

I HAVE BEEN INFORMED OF THE CHOICE OF PROVIDERS AVAILABLE AND UNDERSTAND I MAY CHANGE PROVIDERS AT ANY TIME. I WILL NOTIFY MY CASE MANAGER WHEN I CHANGE PROVIDERS. I HAVE REVIEWED THE SERVICES CONTAINED IN THIS CARE PLAN AND CHOOSE TO ACCEPT THESE SERVICES OFFERED IN:

____ Community ____ Nursing Facility

_____ _____

Signature of Client Date

_____ _____

_.nature of Case Manager Date

___Plan Revision (no client signature required)

SUMMARY OF PLAN REVISIONS		
DATE	REASON	EXPLANATION
	___Medical ___Functional ___Residential ___Psychosocial ___Other:	
	___Medical ___Functional ___Residential ___Psychosocial ___Other:	

DATE	UNMET NEEDS	CRITICAL NEED?	REASON NEED NOT MET

COMMENT SECTION:

INSTRUCTIONS FOR THE LONG TERM CARE PLAN

This form is used by the Single Entry Point agency case manager to develop a service plan for the client. This Long Term Care Plan replaces the 103/104 previously used by the HCBS-EBD program. It also replaces the 403/404 used by the HCBS-PLWA program and the SS-6 used by the Home Care Allowance program.

In this Long Term Care Plan, the case manager checks the areas of concern regarding the client's functioning which were identified through the assessment process. In turn, the corresponding services which the client needs in order to function more effectively are noted. For each service needed, the case manager documents the provider of the service, the funding source, the frequency at which the service is needed and the specific functions of the service which the client needs.

Following the completion of the Plan, the client signs the form to document his/her participation in the planning process.

IDENTIFYING INFORMATION:

The first section of page 1 of the form asks for **identifying information** about the client and the care plan. In the upper left hand corner of the top of the page, record the client's name and a series of identifying numbers---the client's state ID (Medicaid #) number, the number of the county of residence and the number of the Single Entry Point (SEP) agency which is processing the Plan.

Medicaid eligibility status: Check the client's Medicaid eligibility status including whether or not the client is categorically eligible to receive Medicaid or is in the 300% category. If you are not sure which of these categories applies, check with the eligibility technician in the County Department of Social Services. The QMB status refers to whether or not the person is eligible as a Qualified Medicare Beneficiary. If it appears that the client will use private resources to pay for services, check this category.

Programs authorized: Check all of the programs which the client is authorized to receive services from. This list of programs includes the publicly funded long term care programs. (HCA, AFC, HCBS-EBD, HCBS-PLWA), the long term care programs funded by regular Medicaid (Home Health, Hospice) and the private pay component of the SEP agency.

Dates covered by the Plan: Enter the dates covered by the Plan from the beginning of the Plan to the end date, using the month/date/year format, two digits for each, e.g. 07-01-91. These dates must correspond with the program requirements if the person is receiving services from the

HCBS-EBD or HCBS-EBD programs. You will need to check the program rules for this information. If the Plan being completed is a revised Plan, check this category and the date of the revision.

Termination: If the case is being terminated, fill in the date and select from the following codes the reason for the termination.

01--Client no longer financially eligible
02--Client no longer programmatically eligible
03--Nursing facility resident for more than 30 days
04--Client moved out of state
05--Client transferred out of the SEP
06--Client preference to terminate services
07--Client died
08--Other (specify)

AREAS OF CONCERN FROM THE ASSESSMENT:

This section of the Plan requires that you check all of the responses that apply to the client. This is information about the client's functional problems identified through the assessment process which you will use in developing the service plan. Space has been provided for your comments regarding the client's problems.

SERVICE PLAN:

This section of the Plan identifies the services needed by the client and provides information about each of the services which you have identified as needed by the client. The list of services is divided into three categories: 1) Supportive services; 2) Services which are part of the Medicaid state plan benefits; and 3) Single entry point long term care services. In planning for the client's care, keep in mind that you should always consider the most cost effective plan for the individual, selecting those services and providers which can be provided at no cost from family, friends, neighbors and volunteers and then proceeding to the appropriate public programs.

First, select the service(s) needed by the client in each category. Select only those you have identified as needed by the client. For each service, there are five headings or categories of information which you need to fill out for each service selected. Complete this information by going across the form. These headings include:

1. Need or receiving: Circle "R" if the client is currently receving the service; circle "N" if the client needs the service and is currently not receiving it.

2. **Provider name:** Check the appropriate response and write in the name of the provider of the service. Note that this category includes the range of possible providers, including relatives, spouse, non-relative providers and agencies.

3. **Funding source:** If the funding source for the service is known, check the program or funding source which will be used to pay for the service. Responses in this category include the publicly funded long term care programs under the SEP agency, Medicare, specialized public funds (e.g. USDA for food stamps) and private resources, including private insurance.

4. **Frequency:** This category refers to how often the client needs the service. Check the appropriate response. In cases where the service is provided consistently in the same frequency (i.e. food stamps are always provided monthly), the response has been written in. If this response is not correct for your client, write in the correct response. Note that the responses vary depending on the type of service.

5. **Specific functions:** Some of the services have several different functions and clients may need only certain services provided under a broader category; for example, homemaker services include cleaning, meal prep, laundry, etc. Circle all the responses that apply here or write in the response, if appropriate.

SERVICE CATEGORIES:

The following information defines each of the services listed in the Plan. Complete only the parts of this section that are applicable to a particular client; do not complete the sections that are not applicable. The form has been designed to minimize unnecessary repetitive writing by the user of the form, in that some responses have been written in.

Section 1: Supportive Services. This list of services should be considered first in planning for the client's care. They are services which a person might receive from a variety of programs and funding sources outside the long term care programs offered by the SEP publicly funded programs. These services should be considered as supportive in that they can offer the client a living environment which enhances their functioning. For convenience sake, the services have been alphabetized.

Adult Protection: Persons whom you suspect as being "at risk of mistreatment or self-neglect should be referred to Adult Protection at the County Department of Social Services where they reside. An "at risk" adult is defined as an individual age 18+ who is susceptible to mistreatment or self-neglect because he/she is unable to perform or obtain services necessary for their health and safety or lacks sufficient understanding or capacity to make responsible decisions concerning their welfare or affairs. Abuse can include physical pain or injury, nonconsensual sexual conduct, caretaker neglect and financial exploitation. Self-neglect occurs when a person acts or fails to act and endangers

their health, safety, welfare or life by not seeking the necessary services. For more information on adult protection, see Appendix .

Board and Care: Board and care facilities provide room and board and varying levels of protective oversight and supervision for three or more unrelated persons. If the client is in a facility identified as a board and care home, enter the name of the board and care home under "Provider Name". Check the appropriate funding source for the client's care in the facility. Circle all services that the client receives from the facility operator.

Case Management: Although case management is provided through the SEP as part of the administration of the publicly funded long term care programs, private pay clients may need and request case management. Case management usually includes assessment, case planning, service brokering, monitoring and follow-up. However, the model used may vary according to the individual's needs. Write in the provider of case management, the funding source, frequency of need and functions needed.

Dental Care: Dental care can be made available through volunteer dental programs, private pay and the state OAP dental program. Complete the other categories of information for dental care.

Food Stamps: If the client receives or needs Food Stamps, circle this response. You will note that the other responses have been completed for you.

LEAP: If the client needs or is receiving LEAP (Low Income Energy Assistance Program), provided through the County Department of Social Services, simply circle "N" or "R". All other columns for this service have been pre-printed.

Legal Services: Clients may need legal advice or protection in the form of guardianship or conservatorship. Enter the name of the provider and the frequency at which the service is needed. Circle the correct funding source and the functions required.

Meals: Persons who need assistance with meals can have them provided in a congregate setting or at their place of residence. Write the name of the provider under "Provider Name" (e.g. "Brighton Senior Center" or "VOA"). The "Funding Source" column is pre-printed. In the "Frequency" column, specify how often meals are provided. In the Specific Functions section, check the type or location of the delivered meals, whether in a congregate setting or in the client's home.

Mental Health Counseling: Under "Provider Name", list the name of the center or other mental health provider from which the client is receiving mental health services. The "Funding Source" is pre-printed. Under "Frequency", specify how often the client receives services. Under "Specific Functions", list the exact services, (e.g. "grief counseling" or "prolixin injections").

Money Management: Persons may need help managing their money and paying their bills as well as a representative payee to pay their bills. Write in the provider and frequency and check the funding source.

Rehabilitative Services: These services are usually related to work training and preparation. Write in the provider name and the frequencey. Circle the functions which the client need.

Senior Companion: This Federally funded program can provide an older person with an opportunity to earn a stipend by providing assistance in the home to persons in need. In addition, a client might benefit from the services provided by the Senior Companion. Write in the name of the agency providing the program and specify the frequency and functions needed.

Subsidized Housing: A federally funded program which provides rent supplements to persons at lower income levels. Identify the housing facility. The other responses have been completed.

Other Services: This category includes any services not specifically listed above (e.g. VA Aid and Attendant or Title-III funded transportation). Before listing any other services, check the list included on this form to be sure they are not included in any of the other categories. Write the name of the person or agency providing the service under the heading, "Provider Name". Under "Funding Source", specify the source of the funding. Under "Frequency", state how often the client receives the service. Specify the exact nature of the services under "Specific Functions".

Section 2: State Plan Benefits. The following list of services are provided as part of the Medicaid State Plan as both mandated benefits and optional services. You should note, however, that these services can also be purchased through other funding sources, such as from private resources and Medicare.

Please note that home health is listed twice. It is conceivable that an individual could receive home health care from more than one funding source. Use a separate box to identify home health funded by different sources.

Home Health: An assessment on an individual may indicate a need for skilled services offered in the home. If so, it is advisable to have a home health agency assess the need for skilled services. Home Health Aide services can be provided only if skilled personal care is being provided which requires the instruction and direct supervision of a nurse or therapist. Note, that when Home Health services are included in the case plan for Medicaid funded Home Health, the case manager must obtain and file in the case record, a copy of each 60-day Home Health Plan of care. When therapy services are provided, separate plans of care must be furnished by the home health agency.

(All rules and regulations of the Medicaid Home Health program apply to skilled home health services when such services are part of the case plan for HCBS clients).

For Home Health care, identify the provider by the name of the agency, check the appropriate responses for the funding source; check the frequency at which the service is needed by the type of provider, and, write in the specific function required.

Hospice: This program offers palliative and supportive medical services for terminally ill persons. It is offered in the home and in a variety of in-patient settings. Identify the provider and check the funding source.

Medical Equipment: Check if the client needs or is receiving durable medical equipment during this plan period. Write the name of the agency or company providing the equipment under the column, "Provider Name". The "Funding Source" is pre-printed. Under "Frequency", state how often the equipment will be provided. In most cases, this will be "1 X only". Under "Specific Functions", identify the equipment and its purpose.

Other Services: If the client receives any other services, please list them and fill in the other categories of information.

Section 3: Single Entry Point Long Term Care Services. This list of services is available through the long term care programs administrated by the SEP agencies. For the private pay client, many of these services are also available on a fee-for-service basis. There are a number of services which are listed more than once, including homemaker services, non-medical transportation, and personal care. As with services listed more than once in the other categories, this enables you to provide information about a service when it is provided by different programs or funding sources.

Adult Day Care: Health and social services provided on a less than 24 hour basis in state certified facilities. Enter the Adult Day Care provider's name and check the payment source, the frequency at which the client will attend the facility and the functions required.

For "Specific Functions", there are two choices: "Maintenance Model" or "Restorative Model" This refers to the two different types of Day Care facilities that may be certified in Colorado. Most centers are maintenance centers (see 8.491.12a and 8.491.13). If the client is attending a restorative day care center, the center is required to provide daily nursing, physical therapy, occupational therapy and speech therapy, in addition to all the services provided at a maintenance center (see 8.491.12b and 8.491.14). Indicate which of these services the client is receiving from the restorative model day care center by circling all those which apply. You will not circle any of these services if the day care center is a maintenance model.

Assisted Living: Social, supportive and supervisory services provided in a congregate living situation. Enter the name of the facility provider, check the funding source and circle the services which the facility needs to provide for the client.

The Medicaid assisted living program is the Alternative Care Facility program.

Electronic Monitoring: This is electronic equipment or adaptations which enhance the living environment for an individual. Identify the provider of the equipment and check the funding source and frequency responses. The functional section should describe the specific kind of equipment required.

Homemaker: This service includes general household tasks provided by certified agencies to maintain a safe and healthy environment for the client. Some individuals will be receiving homemaker services from different sources and paid for by different programs. Complete both boxes if this situation is applicable for your client. List the provider(s), check the funding source, required visits and the specific functions to be performed for the client.

Home Modification: This service includes home installations or adaptations which are related to the client's physical impairment and which enable the person to remain at home. Enter the name of the provider and check or circle the other responses.

Medical Transportation: The provision of transportation of persons to receive medical care. Identify the provider, check the funding source and write in the frequency at which the transportation is needed and any specific functions.

Non-Medical Transportation: The transportation of persons to services, such as adult day care, which enable the person to remain at home. There are two boxes for a person receiving this transportation from multiple funding sources.

Nursing Facility Care: A facility which provides 24-hour skilled nursing and maintainence care. A client may need to temporarily enter a nursing facility if a medical condition warrants it or enter on a more long term basis when their condition deteriorates. Name the nursing facility and check the funding source.

Personal Care: Services to assist a person with physical limitations and functional needs when the services do not require the supervision of a nurse. There are three boxes so you can identity personal care provided by different programs and funding sources. Check the type of provider (relative, spouse, non-relative or agency) and list the name of the provider. Check the appropriate funding source, the frequency at which the service is needed and the specific tasks required under the function section.

Private Duty Nursing: Skilled nursing visits provided in the home. For the publicly funded long term care clients, this service is available for only HCBS-PLWA clients. Identify the provider and check the payment source and the frequency needed. Circle the specific functions required.

Program for All Inclusive Care (TLC): A comprehensive program of services, including case management and adult day care, provided to frail, elderly persons in the Denver area, operated by Total Long Term Care, Inc. Insert the provider name and check the funding source for your client and the functions needed.

Respite Care: Short-term services for a client to relieve the caregivers from the care and maintenance of the client. Check the kind of provider and list the name. Check the funding source and circle the place where the care is to be provided. Identify the time frame for the provision of the care.

Twenty-Four Hour Personal Care: Personal care provided on a 24-hour basis in the home or a facility. This service is only available for Home Care Allowance clients. Check the provider type and list the name of the provider, the funding source and enter the frequency. Circle the specific functions needed.

Other Services: List any other services which the client may need and complete the necessary information for the service identified.

SIGNATURE SECTION: The last section of the Plan includes a section which the client and the case manager sign. Be sure to have the client read the statement or read it to him/her before signing. The date needs to be included. At the end of the form is a statement which needs to be checked if this Plan is a revision.

If this is a Plan revision, complete the attached page which has two sections: **SUMMARY OF PLAN REVISIONS** and **UNMET NEEDS**. The revision section includes a section on the reason for the revision and an explanation for this. The unmet need section gives you an opportunity to identify any of the client's needs which have not been met, whether these were critical to their health or safety and the reason the needs were not able to be met.

APPENDIX F-1

DESCRIPTION OF PROCESS

a. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

b. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

c. Method of payment (check one):

_X_ Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

___ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

___ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

___ Other (Describe in detail.):

APPENDIX F-2

BILLING PROCESS AND RECORDS RETENTION

a. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

1. When the client was eligible for Medicaid payment on the date of service;

2. When the service was included in the approved plan of care;

All services are prior authorized for specific dates-of-service spans that coincide with level of care re-evaluation dates. The amounts and types of service are entered into a Prior Authorization Request (PAR) file in the MMIS, by client name, Medicaid number, and date of birth. Before a claim can pay, the MMIS verifies against eligibility records that the person had Medicaid eligibility on the date of service. The MMIS also verifies that the services are authorized, and the units paid are decremented from the PAR file.

3. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the client was eligible to receive the services, and the services are not available to the client through a program funded under section 602(16) or (17) of the Education of the Handicapped Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

___ yes.

_X_ no. These services are not included in this waiver.

b. A description of all records maintained in connection with an audit trail is attached. This description details the records maintained by the Medicaid agency, the agency designated in appendix A to oversee the daily operation of the waiver (if applicable), and providers.

MMIS records of PARs and claims are kept on-line and on micro-fiche at the fiscal agent. All providers are required to maintain records adequate to support all claims for 6 years.

c. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

APPENDIX G-1 See Following Pages
OVERVIEW
COST-NEUTRALITY FORMULA

LOC: ____ YEAR __ 1 __ 2 __ 3 __ 4 __ 5

FACTOR	VALUE	FACTOR	VALUE
A	____	A'	
B	____	B'	
C	____	C'	
D	____	D'	
F	____	F'	
G	____	G'	
H			
I			

APPENDIX G-1
OVERVIEW
COST - NEUTRALITY FORMULA

Level of Care: Nursing Facility

Assumes that all individuals are diverted July 1, 1993.

Waiver Fiscal Year 1994

WITH WAIVER		WITHOUT WAIVER	
A =	869	F =	1125
A' =	869	F' =	1125
B =	17450	G =	17450
B' =	5886	G' =	5886
C =	256		
C' =	256		
D =	4548		
D' =	7263		
H =	103	H =	103
I =	1440	I =	1440
Clients served (A+C+H) =	1228	Clients served (F+H) =	1228
Total Costs		F * G =	$19,631,250
A * B =	$15,164,050	F' * G' =	$6,621,750
A' * B' =	$5,114,934		
C * D =	$1,164,288		
C' * D' =	$1,859,328		
H * I =	$148,320	H * I	$148,320
	$23,450,920		$26,401,320
	$19,097		$21,499
With Waiver Costs:	$23,450,920	Without Waiver Costs:	$26,401,320
Net Savings:	$2,950,400		

APPENDIX G-1
OVERVIEW
COST - NEUTRALITY FORMULA

Level of Care: Nursing Facility

Assumes that individuals enter the waiver throughout the year.

Waiver Fiscal Year 1994

WITH WAIVER		WITHOUT WAIVER	
A =	1125	F =	1125
A' =	1125	F' =	1125
B =	14933	G =	17450
B' =	5886	G' =	5886
C =	256		
C' =	256		
D =	2882		
D' =	7263		
H =	103	H =	103
I =	1440	I =	1440
Clients served (A+C+H) =	1236	Clients served (F+H) =	1228

Total Costs			
A * B =	$16,799,625	F * G =	$19,631,250
A' * B' =	$6,621,750	F' * G' =	$6,621,750
C * D =	$737,792		
C' * D' =	$1,859,328		
H * I =	$148,320	H * I	$148,320
	$26,166,815		$26,401,320
	$21,171		$21,499
With Waiver Costs:	$26,166,815	Without Waiver Costs:	$26,401,320
Net Savings:	$234,505		

Calculation of Factors B and D based on phasing in of clients throughout the year.							
	Column A	Column B	Column C			Column D	Column E
July	30	1095	$1,592,316		July	30	$11,370
Aug	30	1065	$1,548,691		Aug	60	$22,740
Sept	30	1035	$1,505,066		Sept	90	$34,110
Oct	25	1010	$1,468,712		Oct	115	$43,585
Nov	25	985	$1,432,357		Nov	140	$53,060
Dec	25	960	$1,396,003		Dec	165	$62,535
Jan	20	940	$1,366,920		Jan	185	$70,115
Feb	20	920	$1,337,836		Feb	205	$77,695
March	15	905	$1,316,024		March	220	$83,380
April	15	890	$1,294,211		April	235	$89,065
May	11	879	$1,278,215		May	246	$93,234
June	10	869	$1,263,674		June	256	$97,024
Totals	256	11553	$16,800,026		Totals	1947	$737,913
Factor B			$14,933		Factor D		$2,882
Column A equals the number of clients entering the waiver each month.							
Column B is the net amount of clients in nursing facilities after subtracting the clients entering the waiver.							
Column C is the monthly total of expenditures in nursing homes.							
Column C is arrived at by multiplying Column B times $1,454.17, the monthly expenditure for nursing facilities.							
Factor B is then the total expenditures in nursing facilities divided by the total number of clients (1,125).							
Column D is the cumulative number of clients in the waiver.							
Column E is the monthly total of expenditures in the waiver.							
Column E is arrived at by multiplying Column D times $379, the monthly expenditure for waiver clients.							

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1
OVERVIEW
COST - NEUTRALITY FORMULA

Assumes no phase-in of clients.

Level of Care: Nursing Facility

Waiver Fiscal Year 1995

WITH WAIVER		WITHOUT WAIVER	
A =	985	F =	1275
A' =	985	F' =	1275
B =	19054	G =	19054
B' =	6525	G' =	6525
C =	290		
C' =	290		
D =	5188		
D' =	8221		
H =	103	H =	103
I =	1565	I =	1565
Clients served (A+C+H) =	1378	Clients served (F+H) =	1378

Total Costs			
A * B =	$18,768,190	F * G =	$24,293,850
A' * B' =	$6,427,125	F' * G' =	$8,319,375
C * D =	$1,504,520		
C' * D' =	$2,384,090		
H * I =	$161,195	H * I	$161,195
	$29,245,120		$32,774,420
	$21,223		$23,784

With Waiver Costs: $29,245,120 Without Waiver Costs: $32,774,420

Net Savings: $3,529,300

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1
OVERVIEW
COST - NEUTRALITY FORMULA

Level of Care: Nursing Facility

Assumes that individuals enterthe waiver throughout the year.

Waiver Fiscal Year 1995

WITH WAIVER		WITHOUT WAIVER	
A =	996	F =	1275
A' =	996	F' =	1275
B =	17796	G =	19054
B' =	6525	G' =	6525
C =	290		
C' =	290		
D =	4926		
D' =	8221		
H =	103	H =	103
I =	1565	I =	1565

Clients served (A+C+H) = 1389 Clients served (F+H) = 1378

Total Costs			
A * B =	$17,724,816	F * G =	$24,293,850
A' * B' =	$6,498,900	F' * G' =	$8,319,375
C * D =	$1,428,540		
C' * D' =	$2,384,090		
H * I =	$161,195	H * I	$161,195
	$28,197,541		$32,774,420
	$20,301		$23,784

With Waiver Costs: $28,197,541 Without Waiver Costs: $32,774,420

Net Savings: $4,576,879

Calculation of Factors B and D based on phasing in of clients throughout the year.							FY 1995
	Column A	Column B	Column B'	Column C		Column D	Column E
July	3	866	878	$1,394,115	July	259	$111,973
Aug	3	863	888	$1,409,993	Aug	262	$113,270
Sept	3	860	897	$1,424,284	Sept	265	$114,567
Oct	3	857	907	$1,440,162	Oct	268	$115,864
Nov	3	854	916	$1,454,452	Nov	271	$117,161
Dec	3	851	925	$1,468,743	Dec	274	$118,458
Jan	3	848	935	$1,484,621	Jan	277	$119,755
Feb	3	845	944	$1,498,912	Feb	280	$121,052
March	3	842	953	$1,513,202	March	283	$122,349
April	3	839	963	$1,529,080	April	286	$123,646
May	3	836	972	$1,543,371	May	289	$124,943
June	1	835	985	$1,564,013	June	290	$125,376
Totals	34	10196		$17,724,946	Totals	3304	$1,428,418
Factor B				$17,796	Factor D		$4,926

Column A equals the number of clients entering the waiver each month.

Column B is the net amount of clients in nursing facilities after subtracting the clients entering the waiver.

Column B' is the net number of individuals in nursing facilities assuming the 13.4% growth.

Column C is the monthly total of expenditures in nursing homes.

Column C is arrived at by multiplying Column B' times $1,587.83, the monthly expenditure for nursing facilities.

Factor B is then the total expenditures in nursing facilities divided by the total number of clients (996).

The 996 is based on the 985 above plus 11 additional deinstitutionalized clients.

Column D is the cumulative number of clients in the waiver.

Column E is the monthly total of expenditures in the waiver.

Column E is arrived at by multiplying Column D times $432.33, the monthly expenditure for waiver clients.

Factor D is then the total expenditures in nursing facilities divided by the total number of clients (290).

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1
OVERVIEW
COST - NEUTRALITY FORMULA

Level of Care: Nursing Facility

Assumes no phase-in of clients

Waiver Fiscal Year 1996

WITH WAIVER		WITHOUT WAIVER	
A =	1117	F =	1446
A' =	1117	F' =	1446
B =	20805	G =	20805
B' =	7232	G' =	7232
C =	329		
C' =	329		
D =	5919		
D' =	9310		
H =	103	H =	103
I =	1700	I =	1700

Clients served (A+C+H) = 1549 Clients served (F+H) = 1549

Total Costs			
A * B =	$23,239,185	F * G =	$30,084,030
A' * B' =	$8,078,144	F' * G' =	$10,457,472
C * D =	$1,947,351		
C' * D' =	$3,062,990		
H * I =	$175,100	H * I	$175,100
	$36,502,770		$40,716,602
	$23,565		$26,286

With Waiver Costs: $36,502,770 Without Waiver Costs: $40,716,602

Net Savings: $4,213,832

APPENDIX G-1
OVERVIEW
COST - NEUTRALITY FORMULA

Level of Care: Nursing Facility

Assumes that individuals enter the waiver throughout the year.
Waiver Fiscal Year 1996

WITH WAIVER		WITHOUT WAIVER	
A =	1129	F =	1446
A' =	1117	F' =	1446
B =	19464	G =	20805
B' =	7232	G' =	7232
C =	329		
C' =	329		
D =	5577		
D' =	9310		
H =	103	H =	103
I =	1700	I =	1700

Clients served (A+C+H) = 1561 Clients served (F+H) = 1549

Total Costs		F * G =	$30,084,030
A * B =	$21,974,856	F' * G' =	$10,457,472
A' * B' =	$8,078,144		
C * D =	$1,834,833		
C' * D' =	$3,062,990		
H * I =	$175,100	H * I	$175,100
	$35,125,923		$40,716,602
	$22,502		$26,286

With Waiver Costs: $35,125,923 Without Waiver Costs: $40,716,602

Net Savings: $5,590,679

Calculation of Factors B and D based on phasing in of clients throughout the year.							FY 1996
	Column A	Column B	Column B'	Column C		Column D	Column E
July	3	982	996	$1,726,815	July	293	$144,522
Aug	3	979	1007	$1,745,886	Aug	296	$146,002
Sept	3	976	1018	$1,764,958	Sept	299	$147,482
Oct	3	973	1029	$1,784,029	Oct	302	$148,962
Nov	3	970	1040	$1,803,100	Nov	305	$150,441
Dec	3	967	1051	$1,822,171	Dec	308	$151,921
Jan	3	964	1062	$1,841,243	Jan	311	$153,401
Feb	3	961	1073	$1,860,314	Feb	314	$154,881
March	3	958	1084	$1,879,385	March	317	$156,360
April	4	954	1094	$1,896,723	April	321	$158,333
May	4	950	1104	$1,914,060	May	325	$160,306
June	4	946	1117	$1,936,599	June	329	$162,279
Totals	39	11580		$21,975,281	Totals	3720	$1,834,890
Factor B				$19,464	Factor D		$5,577

Column A equals the number of clients entering the waiver each month.
Column B is the net amount of clients in nursing facilities after subtracting the clients entering the waiver.
Column B' is the net number of individuals in nursing facilities assuming the 13.4% growth.
Column C is the monthly total of expenditures in nursing homes.
Column C is arrived at by multiplying Column B' times $1,733.75, the monthly expenditure for nursing facilities.
Factor B is then the total expenditures in nursing facilities divided by the total number of clients (1129).
The 1129 is based on the 1117 above plus 12 additional deinstitutionalized clients.
Column D is the cumulative number of clients in the waiver.
Column E is the monthly total of expenditures in the waiver.
Column E is arrived at by multiplying Column D times $493.25, the monthly expenditure for waiver clients.
Factor D is then the total expenditures in the waiver divided by the total number of clients (329).

APPENDIX G-2

METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTORS A AND A'

LOC:

Factor A is computed as follows:

___ Based on institutional utilization trends shown by HCFA Form 2082, minus the number of people estimated in factor C, with adjustment for duplication between the two factors. (To be used for new waivers ONLY.)

___ Based on trends shown by HCFA Form 372, for years _____ of waiver #___, which this waiver is intended to replace.

___ Based on trends shown by HCFA Form 372, for years _____ of waiver #___, which serves the same institutional level population as this waiver.

___ Under section 1915(c)(7) of the Act, this waiver will be limited to those with the specific disease or condition indicated in item 3 of this request. The methodology for deriving specific numbers of persons estimated in factor A is attached to this Appendix.

_X_ Other (specify): Factor A was calculated by taking the actual number of individuals in Nursing Facilities in Fiscal Year 1992 with a primary diagnosis of major mental illness as determined by the pre-admission screens and the annual resident reviews under the PASARR process. This number was inflated by 13.4% foward for each of the next fiscal years. It is assumed that 8.5% of the individuals in nursing facilities would be deinstitutionalized based on the first year of operation of the EBD waiver.

Factor A' is computed as follows:

_X_ A' = A. All those institutionalized at this LOC would receive at least one acute care service.

___ A' is ___ percent of Factor A. According to HCFA Form 372 for years _____ of waiver # ___, which tracks a comparable institutional population, this percentage of institutionalized recipients received acute care services.

___ Computations for this waiver are made according to section 1915(c)(7) of the Act. A description of the methodology is attached.

___ Other (specify):

APPENDIX G-2
Factors B and B'
LOC ____

Factor B is computed as follows:

___ Based on institutional cost trends shown by HCFA Form 2082. (Acceptable for new waivers ONLY.)

_X_ Based on trends shown by HCFA Form 372 for years 1983 through 1992 of waiver # 0006.90.R1, which reflect costs for an institutionalized population at this LOC. These figures are for the EBD waiver and are assumed to be the same for the population requested in this waiver.

___ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. (Section 1915(c)(7) waivers only.)

___ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions and computations attached to this Appendix.

_X_ Other (specify): Using HCFA-372 data from the EBD waiver, inflate actual 1992 cost per client foward using the average increase in the cost per client for the years 1986-1992 as the inflator. This percentage is 9.19%. The cost effectiveness is shown in two ways. The first calculation is based on no phase in of the clients. The second calculation is based on a phase in of the clients and the cost per client is adjusted based on the calculations attached. This phase-in calculation was used for Factor B and for Factor D.

Factor B' is computed as follows:

___ Based on HCFA Form 2082 (New waivers ONLY.)

___ Based on the same HCFA Form 372 used as the basis for the calculation of factor A'.

___ Based on a statistically valid sample of recipients and acute care costs for this LOC.

___ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. (Section 1915(c)(7) waivers only.)

_X_ Other (specify): Using HCFA-372 data from the EBD waiver (#0006.90.R1) for Fiscal Year

1992, use Line II.B.1.a. to arrive at the total cost per client. This cost includes the cost of mental health services. The cost of mental health services was subtracted to arrive at a cost of medical services. The formula is Line IV.A. - MI Services (42,618,442) / Line I.B.1.a. Inflate actual 1992 cost per client foward using the average increase in the cost per client for the years 1986-1992 as the inflator. This percentage is 10.84%. The actual cost per client of mental health services was arrived at by using the claim detail report for FY 1992 that showed an unduplicated number of receipients in nursing homes of 855 with a total cost of $2,618,422. The cost per client of $3,062 was then added to the cost of medical services to arrive at the estimate for B'. The mental health service costs were inflated foward at the 10.84% rate also.

APPENDIX G-2
FACTORS C and C'
LOC:

Factor C is computed as follows:

___ By use of the phase-in/phase-out projection which is attached to this Appendix.

___ Based on HCFA Form 372 for years _____ of waiver # ___, which this waiver is intended to replace.

_X_ Other (specify): Factor C was calculated by taking the actual number of individuals in Nursing Facilities in Fiscal Year 1992 with a primary diagnosis of major mental illness as determined by the pre-admission screens and the annual resident reviews under the PASARR process. This number was inflated by 13.4% foward for each of the next fiscal years. The 13.4% is based on the projected increase in AND population in Colorado for Fiscal Years 1991-1994 as determined by the Department of Social Services. It is assumed that 8.5% of the individuals in nursing facilities would be deinstitutionalized based on the first year of operation of the EBD waiver.

A statistical analysis of the individuals who are in the mental health system and at risk of nursing home placement and would meet the criteria for waiver services indicated that there were 170 qualifying individuals. This number was inflated by 13.4% foward for each of the next fiscal years. It was assumed that 80% of these individuals would enter the waiver.

Factor C is assumed to be the estimate of those deinstitutionalized plus those at risk who would use the waiver services.

Factor C' is computed as follows:

_X_ C' = C. All those institutionalized at this LOC would receive at least one acute care service.

___ The method for computing C' is the same as the method for computing A'.

___ C' is ___ percent of Factor C. According to HCFA Form 372 for years _____ of waiver # ___, which tracks a comparable target population, this percentage of waiver recipients received acute care services.

___ C' is based on HCFA Form 372 for waiver #___, which this waiver is intended to replace.

___ Computations for this waiver are made according to section 1915(c)(7) of the Act. A

description of the methodology is attached.

___ Other (specify):

APPENDIX G-2
FACTOR D
LOC:

Demonstration of Factor D estimates:

Waiver Year 1__ 2__ 3__ 4__ 5

See attached pages.
Cost and services are assumed to be the same as in the EBD waiver.

APPENDIX G-2

ACTOR D

LOC: Nursing Facility

Demonstration of Factor D estimates:

WAIVER FISCAL YEAR 1992

Adult Day Care	*335*	*143*	*$15.36*	*$734,953*
Non-Medical Transportation	*332*	*280*	*$2.54*	*$235,789*
Homemaker	*210*	*142*	*$7.88*	*$235,453*
Personal Care	*2,189*	*504*	*$7.88*	*$8,702,103*
Home Modifications	*63*	*1*	*$728.23*	*$61,171*
Home Electronics	*696*	*8*	*$22.51*	*$123,334*
Alternative Care	*437*	*219*	*$10.77*	*$1,029,847*
Respite Care - All Types	*63*	*10*	*$62.75*	*$41,016*
Grand Total:				*$11,163,665*
Factor C:				*3,195*
Factor D (per capita average): Divide total by Factor C:				*$3,494.10*
Average Length of Stay:				*258.13*

APPENDIX G-2

ACTOR D

LOC: Nursing Facility

Demonstration of Factor D estimates:

WAIVER FISCAL YEAR 1993

Adult Day Care	*412*	*163*	*$16.52*	*$1,110,699*
Non-Medical Transportation	*453*	*272*	*$2.62*	*$321,515*
Homemaker	*376*	*187*	*$8.12*	*$571,135*
Personal Care	*3,043*	*565*	*$8.12*	*$13,976,984*
Home Modifications	*72*	*1*	*$824.42*	*$71,456*
Home Electronics	*749*	*8*	*$23.21*	*$139,393*
Alternative Care	*531*	*258*	*$11.11*	*$1,517,569*
Respite Care - All Types	*65*	*10*	*$68.11*	*$42,245*
Grand Total:				*$17,750,997*
Factor C:				*4,453*
Factor D (per capita average): Divide total by Factor C:				*$3,986.30*
Average Length of Stay:				*262.09*

APPENDIX G-2

ACTOR D

LOC: Nursing Facility

Demonstration of Factor D estimates:

WAIVER FISCAL YEAR 1994

Adult Day Care	452	173	$17.76	$1,391,705
Non-Medical Transportation	497	300	$2.70	$402,858
Homemaker	413	207	$8.38	$715,631
Personal Care	3,343	626	$8.38	$17,513,147
Home Modifications	79	1	$933.31	$89,535
Home Electronics	822	9	$23.93	$174,660
Alternative Care	583	285	$11.45	$1,901,513
Respite Care - All Types	71	10	$73.93	$52,933
Grand Total:				$22,241,981
Factor C:				4,891
Factor D (per capita average): Divide total by Factor C:				$4,547.78
Average Length of Stay:				266.12

APPENDIX G-2

ACTOR D

LOC: Nursing Facility

Demonstration of Factor D estimates:

WAIVER FISCAL YEAR 1995-

Adult Day Care	*493*	*184*	*$19.10*	*$1,729,835*
Non-Medical Transportation	*542*	*333*	*$2.78*	*$500,737*
Homemaker	*450*	*229*	*$8.64*	*$889,502*
Personal Care	*3,642*	*692*	*$8.64*	*$21,768,169*
Home Modifications	*86*	*1*	*$1,056.59*	*$111,288*
Home Electronics	*896*	*10*	*$24.67*	*$217,095*
Alternative Care	*635*	*315*	*$11.80*	*$2,363,508*
Respite Care - All Types	*77*	*11*	*$80.24*	*$65,793*
Grand Total:				*$27,645,928*
Factor C:				*5,328*
Factor D (per capita average): Divide total by Factor C:				*$5,188.35*
Average Length of Stay:				*270.21*

APPENDIX G-2

ACTOR D

LOC: Nursing Facility

Demonstration of Factor D estimates:

WAIVER FISCAL YEAR 1996

Adult Day Care	*533*	*195*	*$20.54*	*$2,135,609*
Non-Medical Transportation	*586*	*368*	*$2.87*	*$618,197*
Homemaker	*487*	*253*	*$8.90*	*$1,098,155*
Personal Care	*3,941*	*766*	*$8.90*	*$26,874,400*
Home Modifications	*93*	*1*	*$1,196.14*	*$137,393*
Home Electronics	*969*	*11*	*$25.44*	*$268,020*
Alternative Care	*687*	*349*	*$12.17*	*$2,917,923*
Respite Care - All Types	*84*	*11*	*$87.10*	*$81,227*
Grand Total:				*$34,130,924*
Factor C:				*5,766*
Factor D (per capita average): Divide total by Factor C:				*$5,919.14*
Average Length of Stay:				*274.35*

APPENDIX G-2
FACTOR D'
LOC:

Factor D' is computed as follows:

___ Based on HCFA Form 372 for years _____ of waiver # ___, which serves a similar target population.

___ Based on a sample of plans of care for recipients with the disease or condition specified in item 3 of this request.

_X_ Other (specify): Using HCFA-372 data from the EBD waiver (#0006.90.R1) for Fiscal Year 1992 to arrive at the total cost per client. This cost excludes the cost of mental health services. Inflate actual 1992 cost per client foward using the average increase in the cost per client for the years 1986-1992 as the inflator. This percentage is 15.71. The actual cost per client of mental health services was arrived at by using the claim detail report for FY 1992 that showed an unduplicated number of receipients in nursing homes of 855 with a total cost of $2,618,422. The cost per client of $3,062 was then added to the cost of medical services to arrive at the estimate for B'. The mental health service costs were inflated foward at a 10.84% rate as detailed in the calculations for B'.

APPENDIX G-2
FACTOR D'
LOC:

Factor D' is computed as follows:

___ Based on HCFA Form 372 for years _____ of waiver # ___, which serves a similar target population.

___ Based on a sample of plans of care for recipients with the disease or condition specified in item 3 of this request.

_X_ Other (specify): Using HCFA-372 data from the EBD waiver, inflate actual 1992 cost per client foward using the average increase in the cost per client for the years 1984-1992 as the inflator. This percentage is 15.71%.

APPENDIX G-2
FACTORS F AND F'
LOC: _____

Factor F is computed as follows:

___ Based on trends shown by HCFA Form 2082 for years _____. (New waivers only.)

___ Based on trends shown by HCFA Form 372 for years _____ of waiver # ___, which this waiver is intended to replace.

___ Based on trends shown by HCFA Form 372 for years _____ of waiver # ___, which serves the same institutional level population as this request.

___ Based on State survey of institutionalized recipients with the disease or condition indicated in item 3 of this request. Descriptions of the survey methodology and results are attached.

_X_ Other (specify): Factor A + Factor C - Duplication.

Factor F' is computed as follows:

_X_ F' = F. All recipients in F would be expected to receive at least one acute care service.

___ Based on the same methodology used to calculate factor A'.

___ Other (specify):

APPENDIX G-2
FACTOR G
LOC:

Factor G is computed as follows:

_X_ G = B.

___ Based on State DRG payments plus payment for outlier days. Description and computations are attached.

___ Based on institutional cost trends shown by HCFA Form 2082 for years _____. (Acceptable for new waivers ONLY.)

___ Based on trends shown by HCFA Form 372 for years _____ of waiver # ____, which reflect costs for an institutionalized population at this LOC.

___ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. (Section 1915(c)(7) waivers only.)

_____ Without the waiver, the following projections apply:

Waiver year_____

a. NUMBER OF BEDS:

1. Number of Currently Certified Beds: _____

2. Beds to be Built and Certified Absent the Waiver (This number is consistent with the projections and documentation included in Appendix G-3.):

_____

b. COST PROJECTIONS:

1. Average per Capita Cost for line a.1.: _____

2. Average per Capita Cost for line a.2.: _____

c. WEIGHTED AVERAGE of lines b.1 and b.2 (equal to factor G):

_____

APPENDIX G-2
FACTOR G'
LOC:

Factor G' is computed as follows:

_X_ G' = B'.

___ Through the same methodology used to obtain factor B'.

___ Factor B' is divided by ALOS in an institution with a waiver to obtain a per diem cost. This cost is then multiplied by ALOS in an institution without a waiver.

___ Other (specify):

APPENDIX G-2
FACTORS H AND I
LOC:

Factor H is computed as follows:

___ Factor H = 0 (zero) for each waiver year. The target population could not be maintained in the community by means of State plan services alone.

___ Based on HCFA Form 2082 for years _____ (new waivers only).

___ Based on HCFA Form 372 for years _____ of waiver # ___, which serves a comparable population.

_X_ Other (specify): A extract of the Department of Social Services data base indicated that there were 103 individuals with a primary diagnosis of major mental illness who receive home health care. Using this data, inflate actual 1992 client count foward using the average increase in the number of clients for the years 1987-1992 as the inflator. This percentage is .07%.

Factor I is computed as follows:

___ Since factor H = 0, factor I also = 0.

___ Based on HCFA form 2082 (new waivers only).

_X_ Based on HCFA Form 372 for years 1985 through 1992 of waiver #0006.90.R1, which serves a comparable population.

_X_ Other (specify): Using HCFA-372 data for waiver clients who use home health services, inflate actual 1992 cost per client foward using the average increase in the cost per client for the years 1987-1992 as the inflator. This percentage is 8.67%.

APPENDIX G-3

BED CAPACITY

LOC

Number of Currently Certified Beds	18,617
Number of Beds to be Built and Certified with waiver	
Number of Beds Projected to be Built and Certified absent the waiver*	
Number of Beds Closed Due to Existing Waiver(s)	
Total Available Beds Without Waiver	18,617
Turnover Rate (Computed according to section 4442.8.C of the State Medicaid Manual)	1.42
Maximum Capacity (Multiply above 2 lines)	26,436
Factor F (subtract)	17,075
Total	9,361

If total is less than zero, the waiver cannot be approved, as there is not sufficient bed capacity to justify the number of individuals proposed to be served.

*Beds projected to be built and certified absent the waiver:

Actual CON's	0
Other approved construction/conversion	0
CONS's which have been or will be denied with waiver in effect (document on attachment)	0
Other construction/conversion which will be denied with waiver in effect (document on attachment)	0
Total	0

APPENDIX G-3

C: Nursing Facility *DOCUMENTATION:*

The number of licensed beds is taken from the Colorado Department of Health, Health Facilitates Division's listing of licensed beds for the fourth quarter ending December 31, 1992. This listing documents all licensed beds for the aged and disabled, whether the facility is certified for Medicaid or not. The Medicaid only licensed bed count is unavailable. It is assumed that all non-Medicaid facilities would enter into agreements with the Department if the demand for nursing facility services were to rise to the level that the currently non-certified beds would be needed for Medicaid clients.

Certificates of Need have not been required in Colorado since the implementation of the waiver. Therefore, no information is available.

The number of licensed beds historically available in Colorado (as reported by the Health Facilities Division) for the quarters ended 12/31 each year, is as follows:

YEAR	TOTAL BEDS	PERCENTAGE CHANGE	OCCUPANCY RATE	VACANT BEDS
1988	18,713	8.72%	87%	2,389
1989	19,592	4.70%	83%	3,277
1990	20,115	2.67%	83%	3,430
1991	20,028	<0.43%>	84%	3,240
1992	20,093	0.32%	85%	3,047

The number of beds currently certified is:

20.093 - 1,476 non-Medicaid Beds = 18,617.

The turnover rate is computed from the HCFA-2082, Section F(1), for the period ending 9/30/92. The computations are as follows:

3,752,679 days ÷ 14,613 = 256.8 days per client; 365 ÷ 256.80 = 1.42

An alternate calculation is made from the HCFA-372 for Waiver Number 0006.90.R1, for the period ending 6/30/92. The computations are as follows:

3,825,314 ÷ 14,436 = 264.98; 365 ÷ 264.98 = 1.38

The computation from the HCFA-2082 is used as that is the direction in the State Medicaid Manual.

APPENDIX G-4

WAITING LISTS

LOC	NUMBER ON WAITING LIST	AVERAGE WAIT (IN DAYS)

Check if applicable:

___ All recipients would be served in acute care hospitals absent the waiver. There are no waiting lists.

___ Data are based on a sample of facilities at this LOC.

_X_ The State does not maintain these data.

APPENDIX G-5

DEINSTITUTIONALIZATION/DIVERSION

Deinstitutionalization:

Waiver Year	Loc	Number Deinstitutionalized in that Year
1	Nursing Facility	81
2	Nursing Facility	11
3	Nursing Facility	12

Diversion :

Waiver Year	Loc	Number Diverted in that Year
1	Nursing Facility	175
2	Nursing Facility	23
3	Nursing Facility	27

Sources of Diverted Recipients (in estimated numbers or percentages): Please see Appendix G-@ Factor A and C..

APPENDIX G-6

UNDUPLICATION

LOC:

YEAR FACTOR F - FACTOR A - FACTOR C + DUPLICATION = 0

Year	Factor F -	Factor A -	Factor C +	Duplication =	0
1	1125	1125	256	256	0
2	1275	996	290	11	0
3	1446	1129	329	12	0

APPENDIX G-7 See G-1 pages.

AGGREGATE AND PER CAPITA COST-EFFECTIVENESS

LOC:_____ YEAR__1 __2 __3 __4 __5

$$\frac{(AxB) + (A'xB') + (CxD) + (C'xD') + (HxI)}{F + H} \leq \frac{(FxG) + (HxI) + (F'xG')}{F + H}$$

A x B = _____ A' x B' = _____

C x D = _____ C' x D' = _____

F x G = _____ F' x G' = _____

H x I = _____

Compute with Formula Values:

Aggregate Cost: Without Waiver

With Waiver

Aggregate Savings

Per Capita Cost: Without Waiver

With Waiver

Per Capita Savings